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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, *et al.*,
Petitioners,

vs.

ROSIER JENNINGS, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

JOINT APPENDIX

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DOCKET ENTRIES

Documents and Entries	Date
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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
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State of Tennessee, et al.,
Defendants.

COMPLAINT - CLASS ACTION

Preliminary Statement

This is a class action brought by and on behalf of Tennessee Medicaid recipients for declaratory and injunctive relief from reductions in services which the Tennessee Department of Public Health plans to implement on August 15, 1980. If the proposed reduction in outpatient hospital visits from thirty (30) per year to six (6) per year, the proposed restriction on drugs covered under the Medicaid formulary and the proposed freeze on Medicaid formulary and the proposed freeze on Medicaid beds in intermediate care facilities are implemented by The Department of Public Health, the plaintiffs will suffer irreparable harm to their health that no amount of money will compensate nor any amount of remedial health care will correct. If the proposed physician reimbursement rate is implemented, a number of private physicians will drop out of the Medicaid program and many Medicaid recipients will have no doctor to provide their basic medical services.

Plaintiffs challenge the proposed reductions in services on the grounds that they conflict with Title XIX of the Social Security

Act. The proposed reductions (a) will result in the Medicaid program's failure to provide medical services in sufficient amount, duration, and scope to reasonably achieve their purpose; (b) bear no relation to medical necessity; and (c) discriminate on the basis of diagnosis or treatment. The plaintiffs maintain that by proposing and implementing these reductions the defendants have denied benefits to handicapped persons in violation of the Rehabilitation Act of 1973 and the defendants have discriminated against racial minorities in violaiton of the Civil Rights Act of 1964. Plaintiffs further maintain that the intentional proposal of racially discriminatory service reductions by defendants Fowinkle and Crim violation the Equal Protection Clause of the United States Constitution.

Plaintiffs challenge the procedural implementation of the reductions on the ground that the defendants' failure to consult the Tennessee Medicaid Medical Advisory Committee and failure to provide adequate notice of the reductions to recipients are in violation of federal law and regulations. Further, plaintiffs maintain that the defendants' failure to provide adequate notice and opportunity for hearing prior to implementation of the reductions in services violates their constitutional right to due process of law.

Plaintiffs face irreparable injury and harm for which there is no adequate remedy at law. Plaintiffs, therefore, seek a temporary restraining order and a preliminary injunction, in addition to appropriate declaratory relief.

Jurisdiction

1. The court is vested with jurisdiction in this case by 28 U.S.C. § 1343(3) and (4), which provide for original jurisdiction in all suits arising under 42 U.S.C. § 1983. Jurisdiction is also conferred pursuant to 28 U.S.C. § 1331 which grants jurisdiction in matters arising under the Constitution and laws of the United States. The Medicaid coverage at stake for each named Medicaid plaintiff and each member of the plaintiff class exceeds $10,000.

2. Plaintiffs' request for declaratory and injunctive relief is authorized by 42 U.S.C. § 1983, 42 U.S.C. § 2000d, 28 U.S.C. § 2201 and § 2202 and Rule 57 of The Federal Rules of Civil Procedure.

Parties

3. Plaintiffs Rosier Jennings, Herschel Choate, Wilma Ann Hyder, Clyde Vaughn, Eldon Kerr, Stella Harris, Sadie Owens, Margaret Betty Baldwin, Charles Baldwin, and Carrie Clemmons are all adult citizens of the United States, residents of Tennessee and Medicaid recipients.

4. Paul Ramone Parsons, Michelle Ogle, Rebecca West, Mary Baldwin and Charles Baldwin are minors who are residents of Tennessee and recipients of Medicaid. These children, along with Rosier Jennings and Clyde Vaughn who are incompetent, bring this action by next friends as stated in the caption.

5. Defendant Lamar Alexander is the Governor of the State of Tennessee, and, as such, is vested with the Supreme Executive Power of the State by Article III, Section 1 of the Constitution of Tennessee. Defendant Alexander is responsible for the administration of State government, including administration of the Medicaid program. 45 C.F.R. §201.3(a) requires that the Governor be consulted before any amendments are made in the Medicaid plan. The Governor is also responsible for establishing a Medical Care Advisory Committee, a committee which advises The Department of Public Health on the Medicaid program. *Tenn. Code Ann.* § 14-23-120. Defendant Alexander is sued in his official capacity.

6. Defendant Eugene Fowinkle is the Commissioner of the State of Tennessee Department of Public Health and, as commissioner, is charged with the overall responsibility for the administration of the State's Medicaid program. His duties include adopting and implementing policies that conform to applicable federal laws and regulations. Defendant Fowinkle is

sued both individually and in his official capacity as Commissioner.

7. Defendant Ben Crim is Assistant Commissioner of the Department of Public Health, and is charged with administration and coordination of the Medicaid program. Defendants Fowinkle and Crim are sued both in their official capacities and as individuals.

8. Defendant Carolyn Hale is the Director of the Cumberland County Department of Human Services. Under a federally approved contractual arrangement with The Deparment of Public Health, the Department of Human Services is responsible for conducting fair hearings on grievances pertaining to the Medicaid program. Each county director is responsible for assuring that hearings are provided and conducted in compliance with federal law. Defendant Hale is sued in her official capacity and as a representative of all Department of Human Services County Directors.

Class Action Allegations

9. Pursuant to Rule 23 of the Federal Rules of Civil Procedure the named plaintiffs bring this suit on behalf of themselves and the class of all Tennessee Medicaid recipients. In addition, this class contains three subclasses.

a. Plaintiffs Harris and Clemmons represent a subclass of Medicaid recipients who are members of a racial minority.

b. Plaintiffs Jennings, Owens, Ogle, West and Parsons represent a subclass of handicapped Medicaid recipients.

c. Plaintiff Mary Baldwin represents a subclass of Medicaid recipients who received no notice of the proposed reductions in the Medicaid program.

10. The pre-requisites of Rule 23(a) are met for the class and its subclasses in that:

(a) The class has so many members that joinder of all members is impracticable; upon information and belief. There are more than 300,000 Medicaid recipients in the State of Tennessee.

(1) Upon information and belief, there are more than 150,000 Medicaid recipients who are members of a racial minority.

(2) Upon information and belief, there are thousands of handicapped Medicaid recipients in the State of Tennessee.

(3) Upon information and belief there are at least 200 Medicaid recipients who received no notice of the impending cutbacks because they were wrongfully terminated from Medicaid for a brief period of time.

(b) There are questions of law or fact common to all members of the class. These questions include: Whether Medicaid recipients are being unlawfully denied adequate notice and an opportunity for a hearing before reduction of Medicaid benefits? Whether Medicaid recipients are being denied Medicaid coverage sufficient in amount and scope to achieve its purpose? Whether Medicaid recipients are being discriminated against on the basis of diagnosis?

(1) In addition the subclass of all racial minority Medicaid recipients raises common questions of law which include: Whether minority recipients are being unlawfully discriminated against by the reductions in outpatient services and the restrictions on the formulary?

(2) In addition the subclass of all handicapped Medicaid recipients raises the common questions of:

Whether handicapped individuals are being unlawfully discriminated against on the basis of their handicaps by the reductions in out-patient care, the restrictions on the formulary and the freeze on Medicaid funded beds in intermediate care facilities?

(c) The claims of the named plaintiffs are typical of the claims of the class. All Tennessee Medicaid recipients are entitled to adequate notice and opportunity for hearing. All Tennessee Medicaid recipients are entitled to Medical services which are sufficient in amount and scope to reasonably achieve their purposes.

(1) The claims of the named plaintiffs in their subclass of racial minority Medicaid recipients are typical of the claims of their subclass. All minority Medicaid recipients are entitled to receive the same medical services as other Medicaid recipients.

(2) Additionally the claims of the named plaintiffs in the subclass of handicapped individuals are typical of the claims of the class. All handicapped Medicaid recipients are entitled to receive Medicaid services equivalent to services received by non-handicapped individuals.

(d) The named plaintiffs will fairly and adequately protect the interests of the class. The named plaintiffs have a sharply drawn, personally vital controversy with the defendant which dictate that they will fully and vigorously prosecute this action. At stake for all of the named plaintiffs is a continuation of or improvement of their current health status and for some of the named plaintiffs even have their lives at stake. The plaintiffs are represented by non-profit legal services organizations experienced in class action litigation. The relief sought for the individual plaintiffs is identical with the relief sought for the class as a whole.

11. Plaintiffs seek certification of the class under the provisions of Rule 23(b) (1) in that the prosecution of separate actions by individual members of the class would create a risk of inconsistent or varying adjudications which would establish incompatible standards of conduct for the party opposing the class and would as a practical matter be dispositive of the interests of other members not party to the adjudication.

12. Plaintiffs also seek certification of the class under the provisions of Rule 23(b)(2) in that the defendants' action to terminate services will generally affect the entire class of medicaid recipients in reducing Medicaid services as will be defendants failure to implement the reductions in services in compliance with federal law.

Statutory and Regulatory Scheme

13. The purpose of the Medicaid program is to provide assistance to eligible individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

14. The Medicaid program is funded and administered through cooperation of the federal and state governments, pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*. The program provides certain necessary medical services to certain categorically eligible and indigent persons. States such as Tennessee which choose to participate in the Medicaid program must comply with the requirements of Title XIX and regulations promulgated under the authority of Title XIX by the United States Department of Health and Human Services. A state wishing to establish a Medicaid program must submit a state plan for medical assistance which provides that the state will meet the requirements of federal law. 42 U.S.C. § 1396.

15. A state participating in the Medicaid program is required to provide Medicaid to persons receiving Aid to Families with Dependant Children (AFDC). A state must elect to provide

Medicaid to one of several other categories of persons and Tennessee has elected a category including, among others, all persons receiving Supplemental Security Income (SSI) benefits. 42 U.S.C. § 1396(a)(10)(A).

16. A state may provide Medicaid coverage for other needy individuals, and Tennessee has elected to provide partial coverage for individuals who are categorically eligible for AFDC or SSI benefits but whose income is too high for them to receive these benefits. These individuals are termed "medically needy" or "exceptionally medically needy". 42 U.S.C. § 1396(a)(10)(C).

17. In order for the state to receive federal funds, the state must offer certain required medical assistance services, including certain inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services, early and periodic screening, diagnosis, and treatment services of children under 21, family planning services and supplies, and physician services. 42 U.S.C. § 1396(a)(13)(B).

18. In addition a state may elect, as Tennessee has done, to cover other enumerated types of services for which federal reimbursement is available. Included among these "optional" services which Tennessee has elected to provide are home health services, clinic services and prescribed drugs.

19. Pursuant to 42 U.S.C. § 1396c, the Tennessee Department of Public Health has contracted with the Social Security Administration to make determinations of Medicaid eligiblity on behalf for individuals receiving or eligible for Supplemental Security Income benefits.

20. Pursuant to 42 U.S.C. § 1396a(a)(5) the Tennessee Department of Public Health has contracted with the Tennessee Department of Human Services (DHS) to make determinations of Medicaid eligiblity on its behalf for individuals who are receiving or eligible for Aid to Families with Dependent

Children. The contract also provides that the Department of Human Services will be responsible for conducting fair hearings on grievances pertaining to Medicaid eligibility and entitlement.

21. DPH has also contracted with Electronic Data Services Federal Corporation (EDSF) to process claims for Medicaid coverage.

Factual Allegations

1. Impending Cutbacks

22. On or about July 1, 1980, some Medicaid recipients received notices of proposed reductions in services covered by Medicaid and a general notice that payments to some Medicaid providers would be reduced. (See Attachment A) Although these notices did not specify which reductions would be made in the Medicaid program, among other things, they indicated the formulary might be restricted, the prescriptions Medicaid would pay for monthly might be reduced, hospital outpatient visits might be significantly reduced except in hardship circumstances and the number of Medicaid reimbursed beds in intermediate care facilities might be reduced.

23. The notices to Medicaid recipients did not specify which drugs would be deleted from the formulary. Although the notices indicated exceptions would be made in hardship cases for outpatient hospital care, no guidelines were given on qualifications for the hardship exception. Upon information and belief the Tennessee Department of Public Health has no published standards for determining qualifications for hardship circumstances or procedures for prior approval.

24. Upon information and belief the readability level of the July 1, 1980 notices to recipients is above the eleventh grade level and the average educational attainment of Medicaid recipients in Tennessee is at the eighth grade level.

25. The Medicaid recipient notices did not explain the circumstances under which a hearing would be granted if requested and an explanation of the circumstances under which Medicaid would be continued if a hearing was requested.

26. The notice of reduction in Medicaid benefits was not received by plaintiff Margaret Betty Baldwin and the class of Medicaid recipients she represents. Upon information and belief, the notices of Medicaid reductions were not sent to an entire class of Medicaid recipients, including, but not limited to, approximately two hundred (200) Medicaid recipients who were wrongfully terminated from the Medicaid program for a brief period of time.

27. On July 28, 1980, the Tennessee Department of Public Health mailed exact proposed rule changes to county offices of the Tennessee Department of Human Services. (Attached as Exhibit C) Upon information and belief, these are the changes that will be implemented in the Medicaid program. Upon information and belief, Medicaid recipients have received no notice of these exact changes.

28. The Tennessee Medicaid Medical Advisory Committee is authorized by *Tenn. Code Ann.*, 14-23-120, and members of that committee are appointed by the Governor of the State of Tennessee. Upon information and belief there are presently no consumers and no members of racial minorities on that committee.

29. Upon information and belief, a meeting of the Tennessee Medicaid Medical Advisory Committee has not been convened at any time during calendar year 1980. Nor has the Medicaid Medical Advisory Committee been consulted about the reductions in the Medicaid program.

30. The racially discriminatory effect of defendants' proposed reduction of services and reimbursement are striking and are well known to the defendants. The *Tennessee Department of*

Public Health, Statistical Report on Medical Care: Recipients, Payments and Services, Fiscal Year 1978 (1/4/79) shows that in the existing Medicaid program for every dollar spent on white Medicaid recipients, only 53 cents is spent on minority recipients, despite the fact that the health status of blacks is generally poorer than that of whites.

31. The state's proposed cutback in hospital outpatient services exacerbates rather than rectifies these striking inequities. In attempting to cut Medicaid expenditures, Tennessee has targeted one of the few services in which a disproportionate share of Medicaid funds is spent meeting the needs of black patients. For although blacks receive only 29.95 per cent of all Medicaid funds, 56 per cent of the Medicaid dollars spent on outpatient hospital services are provided to minority patients. Of the black share of Medicaid funds 7.55 per cent is spent for the purchase of outpatient hospital services, but only 2.53 per cent of the white share of Medicaid funds is spent for outpatient services. This greater dependence by blacks on outpatient hospital services is related to well documented occurrences of chronic diseases in the black population. The traditional patterns of discrimination in access to private health care by blacks, fostered in part by official state action, also accounts for the greater dependence by minorities on outpatient hospital services.

32. Upon information and belief a numnber of categories of medically necessary drugs will be deleted from the Medicaid formulary and will no longer be available for Tennessee Medicaid recipients. (See Attachment B) For example, these formulary deletions will have a significant impact on all pre-natal women, children with iron-deficiency anemia, epileptics and older people with chronic respiratory problems.

33. Upon information and belief, the proposed restrictions in the formulary will have a discriminatory impact on racial minorities. For example, the proposed formulary deletes all

vitamins, including pre-natal vitamin supplements. In its impact on maternal and infant mortality and morbidity, this aspect of the state's plan complements the intended curtailment of pre-natal outpatient care. The correlation between low birth weight ratios stemming from poor pre-natal nutrition, and the racially disparate frequency of infant mortality is well documented. In Tennessee, 1977 statistics show that black infants with low birth weights are twice as numerous as white infants with low birth weights.

34. Upon information and belief, the reduction in physician reimbursement rates will result in decreased physician participation in the Medicaid program leaving many Medicaid recipients without private physicians.

35. Upon information and belief, the ceiling on Medicaid reimbursed nursing home beds will in effect freeze the number of beds funded by Medicaid at the present level in no relation to the number of people who need those beds.

II. **Named Plaintiffs**

36. Rosier Jennings is a seventy-seven (77) year old stroke victim who has been bedridden for nine (9) years, and has a medical history of high blood pressure and of recurring bronchitis. Mr. Jennings' physician prescribes cough and cold medications for the treatment of bronchitis and to prevent Mr. Jennings' frequent colds from causing him pneumonia, and also prescribes potassium to replace that depleted from Mr. Jennings' body as a side effect of the drugs he uses to control his hypertension. Upon information and belief, the proposed revisions in the Medicaid formulary would deny coverage of these essential medications. Mr. Jennings and his wife, Kathleen Jennings, reside in Jamestown, Tennessee. Their entire income is from Social Security benefits and Supplemental Security Income. Mrs. Jennings, with the help of home health services, has faithfully cared for Mr. Jennings. If his precarious physical condition worsens in any way, she will no longer be able to care for

him at home and will have to admit him into an Intermediate Care Facility. Yet, the availability of such treatment will be jeopardized by the impending freeze on the number of beds covered by Medicaid.

37. Hershel Choate, of Jamestown, Tennessee, receives Supplemental Security Income as a result of his total disability due to epilepsy. To control his epilepsy, Mr. Choate's physician has prescribed three drugs: dilantin, phenobarbitol, and valium. The valium tablets, which on information and belief are to be deleted from the Medicaid formulary, are prescribed both as an adjunct to his other prescriptions and as a preventative measure to decrease the likelihood of seizures.

38. Wilma Ann Hyder, a resident of Crossville, Tennessee, has had uncontrollable diabetes for a 21 year period. Social Security determined Ms. Hyder to be completely and permanently disabled eight years ago after she had a suprapubic cystotony requiring the insertion of a tube in her stomach. This tube requires continual maintenance and is a constant source of urinary tract infections. Ms. Hyder has other multi-system disorders resulting from her diabetes and is now almost totally blind. To relieve pain from neuropathy, and in hopes that it can control her neuropathy, Ms. Hyder's physician prescribes biweekly injections of Vitamin B-12, a vitamin which will be deleted from the formulary. Ms. Hyder also sees a psychiatrist monthly at the Cumberland Medical Center outpatient clinic. Ms. Hyder receives Medicaid through the medically needy spend down program, since she spends more than $200 monthly for her medical care.

39. Clyde Vaughn, a resident of Crossville, Tennessee, is a fifty-seven (57) year old male with multiple medical problems. Mr. Vaughn has respiratory problems, gastrointestinal problems and a brain tumor. Mr. Vaughn is frequently a hospital inpatient. In addition, Mr. Vaughn must use the hospital emergency room on weekends. Mr. Vaughn's doctors presently

prescribe nine (9) drugs for his medical condition. If the formulary restrictions are implemented, Mr. Vaughn will not be able to get all of his drugs.

40. Paul Ramone Parsons is a fourteen (14) year old resident of Crossville, Tennessee, who suffers from ostaochondramatosis, a hereditary bone disease. This bone disease causes tumors to grow on Paul's bones and surgery is required to remove them. Since Paul's condition was discovered twelve years ago, he has had extensive surgery. After surgery, Paul is extremely susceptible to bone fractures. This bone condition has caused Paul's bones to grow improperly. Last year Paul was admitted to the emergency room at Cumberland Medical Center eight (8) times. Many of these visits occurred shortly after surgery and some visits were the result of accidents. Paul's condition makes it very probable that he will need emergency room services this year in excess of the two uses allowed by the proposed reductions in services.

41. Rebecca West is a six (6) year old victim of cerebral palsy who resides in Cleveland, Tennessee. She receives physical therapy at a hospital outpatient unit several times a month, and last year she exceeded the thirty (30) day visit limit then in effect. Her mother has been advised that, without faithful adherence to the therapy regime, Rebecca will never be able to walk.

42. Michelle Ogle is a nine and a half (9 1/2) year old child residing with her mother in Cleveland, Tennessee. Michelle is quadriplegic, totally blind, and suffers profound psycho motor retardation. She spent two months within the past year in an intermediate care nursing home, and is frequently hospitalized. Due to her low resistance to disease, she sees her physician on an average of five times per month and has been admitted to a hospital emergency room from eight to ten times in the past year, frequently for pneumonia. She receives several prescription drugs as well as gamma globin.

43. Eldon Kerr is a thirty-eight (38) year old SSI recipient who is a hemophiliac, has epilepsy, peptic ulcers and is missing a leg. He has been hospitalized for much of his life and must make frequent visits to the emergency room because of his medical condition.

44. Stella Harris is a thirty-nine (39) year old black female with sickle cell anemia who receives Supplemental Security Income. In addition to requiring hospitalization, her condition makes her dependent upon frequent treatments as a hospital outpatient. Ms. Harris resides in Chattanooga, Tennessee.

45. Sadie I Owens, of Fayetteville, Tennessee, is a paraplegic victim of multiple schlerosis and other medical problems. Despite her handicap, she cares for her three children who live with her. Last year she was hospitalized in excess of the present twenty (20) days of inpatient Medicaid coverage and used the hospital emergency room on two occasions. Because of the progressive nature of Ms. Owens' illness, she may well need emergency room treatment this year in excess of the proposed emergency room limitations.

46. Margaret Betty Baldwin, a resident of Nashville, Tennessee, is a thirty-nine (39) year old permanently and totally disabled woman who is receiving Supplemental Security Income, making her automatically eligible for Medicaid. She suffers from a chronic bladder infection, a nervous disorder, chest disease with congestion, migraine headaches and sinus trouble. Her doctor recently dropped out of the Medicaid program after state officials began to discuss cutbacks. Despite the fact that she lives in an urban area served by a large number of physicians, nearly all of them refuse to participate in the Medicaid program and she has been unable to find a physician who accepts Medicaid patients and will treat her. Ms. Baldwin must go for outpatient treatment at a hospital clinic in Nashville every six weeks but will soon exhaust her Medicaid coverage for such visits if the cutback is implemented. If the restricted drug for-

mulary goes into effect, Ms. Baldwin will be unable to obtain medications prescribed for the control of her bladder infection and nervous disorder.

47. Ms. Baldwin's husband, Charles, is forty-nine (49) years old and also disabled. He received medical treatment at the same hospital clinic attended by Ms. Baldwin. If the restricted drug formulary goes into effect, Mr. Baldwin will not be able to obtain necessary medications prescribed by his physicians.

48. The Baldwins' daughter, Mary, age thirteen (13), has three medical problems: epilepsy, asthma, and severe psorasis. The Social Security Administration has found her to be disabled, primarily as a result of her psorasis.

49. The Baldwins' grandons, Charles, age seventeen (17) months, has epilepsy and an acute iron deficiency anemia. He must visit outpatient hospital facilities in excess of twenty times a year. If the limitation on outpatient visits goes into effect Charles will be unable to obtain necessary medical treatment. If the restricted drug formulary goes into effect Charles will no longer be able to obtain medication prescribed for the treatment of his anemia. The condition will become more severe and he will not develop properly. Charles' medical are so severe that they have already caused the loss or part of his tongue.

50. Carrie Clemmons, a resident of Nashville, Tennessee, is a forty-six (46) year old black woman who is totally disabled, subsisting on Supplemental Security Income and Social Security. She has diabetes, hypertension, seizure disorders, heart disease, sinus trouble, phlebitis and a nervous disorder. Since July 1, 1980, Ms. Clemmons has been to the emergency room on three occasions thereby exceeding the proposed limitation of two emergency visits per year. If the restricted drug formulary goes into effect Ms. Clemmons will not be able to obtain two of the medications prescribed for her by her doctors.

51. If the proposed changes in the Medicaid program go into effect the plaintiffs and the class of Medicaid recipients they

represent will suffer irreparable harm to their health no amount of money will compensate nor any amount of remedial health care will correct. The types of injury and harm demonstrated in the personal circumstances of the named plaintiffs epitomize the kinds of injuries which will be sustained by members of the plaintiff class as a whole as a result of the impending withdrawal of necessary medical services. Plaintiffs have no adequate remedy at law.

First Cause of Action

52. In order to receive federal funds under the Medicaid program, each state must establish standards and methods to assure the delivery of high quality care. 42 U.S.C. § 1396a (22)(D). The federal regulations require each state to establish a Medical Care Advisory Committee whose members must be selected from certain enumerated interest groups. 42 C.F.R. § 431.12(d) The Medical Care Advisory Committee (MCAC) must include "members of consumers' groups, including Title XIX recipients, and consumer organizations . . ."

53. The present composition and selection mechanisms of the Medicaid Medical Advisory Committee violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.* and 28 C.F.R. § 42.104(d)(1) and (2), and the requirement that the MCAC contain representatives of consumers, including Title XIX recipients, and of consumers groups, 42 C.F.R. § 431.12(d)(2).

Second Cause of Action

54. The Medical Care Advisory Committee, once constituted, is to "have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program." 42 C.F.R. § 431.12(e).

55. The defendants have refused or failed to consult a properly constituted Medical Care Advisory Committee prior to the final decision to reduce Medicaid services and provider reimburse-

ment, in violation of 42 U.S.C. § 1396a(a)(22)(I) and 42 C.F.R. § 431.12(e).

Third Cause of Action

56. The state agency administering the Medicaid program is required to give advance notice to Medicaid recipients of any action to reduce Medicaid services. The notice required must contain:

> "(a) a statement of what action the agency intends to take;
>
> '(b) the reasons for the intended action;
>
> '(c) the specific regulations that support, or the change in federal or state law that requires, the action;
>
> '(d) an explanation of (1) the individual's right to request an evidentiary hearing if one is available, or a state agency hearing; or (2) in cases of an action based on a change of law, the circumstances under which a hearing will be granted; and
>
> '(e) an explanation of the circumstances under which Medicaid is continued if a hearing is requested."

42 C.F.R. § 431.20

57. The defendants have refused or failed to provid Medicaid recipients with adequate notice of the exact changes in services covered by the program, to provide recipients with notice of their right to a fair hearing and continued assistance pending that hearing, and an opportunity for such a hearing, in violation of 42 U.S.C. § 1396(a)(3), 42 C.F.R. § 431.206, 42 C.F.R. § 431.220 and in violation of plaintiffs' right to due process of law as guaranteed by the Fourteenth Amendment to the United States Constitution.

Fourth Cause of Action

58. The defendants have restricted the number of outpatient hospital visits, a service used much more by racial minorities

than by whites and removed drugs from the Medicaid formulary which disparately impact on minority Medicaid recipients in violation of 42 U.S.C. § 2000d *et seq.* and 45 C.F.R. § 80.1 *et seq.* which prohibit discrimination in programs receiving federal financial assistance.

Fifth Cause of Action

59. The defendants have restricted the number of outpatient hospital visits, eliminated drugs from the Medicaid formulary and frozen the number of reimbursed Medicaid beds in intermediate care facilities in violation of 42 U.S.C. § 1396a and 42 C.F.R. §§ 440.230(b) and (c)(2) which require that services be provided under the state plan in sufficient amount, duration, and scope to reasonably achieve their purpose, and which provide that services may appropriately be limited based on medical necessity or utilization control procedures.

Sixth Cause of Action

60. The defendants have reduced physician reimbursement rates to such an extent that the Tennessee Medicaid program is in violation of 42 C.F.R. § 447.204, which mandates that physician reimbursement rates under the state plan shall be formulated so as to encourage availability of medical services to Medicaid recipients comparable to availability of those services to the general public, and 42 C.F.R. § 440.230(b) which requires that each service be available in sufficient amount to reasonably achieve its purpose.

Seventh Cause of Action

61. The defendants deletion of drugs from the Medicaid formulary which are particularly needed by persons with handicapping conditions, the defendants restriction of outpatient hospital visits for therapy and defendants freeze on Medicaid reimbursed beds in intermediate care facilities are in violation of § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which prohibit discrimination against handicapped individuals in any program which receives federal financial assistance.

Eighth Cause of Action

62. The defendants deletion of drugs from the Medicaid formularly which are needed by persons with particular diseases, their restriction of outpatient hospital visits which are necessary to persons with certain conditions and their restriction in Medicaid reimbursed beds in intermediate care facilities are in violation of 42 U.S.C. § 1396a and 42 C.F.R. § 440.230(c)(1) which prohibit denial or reduction of services based on diagnosis, type of illness or condition.

Ninth Cause of Action

63. Defendants Fowinkle and Crim have violated the right of racial minority recipients to equal protection of law in violation of the Fourteenth Amendment of the United States Constitution by intent and effect in proposing and implementing discriminatory reductions in Medicaid benefits.

Relief Requested

WHEREFORE, plaintiffs, individually and on behalf of their class, request that the Court grant the following relief:

1. Assume jurisdiction of this cause, certify the plaintiff class and maintain continuing jurisdiction until the rights of the parties are finally determined.

2. Grant a temporary restraining order restraining defendants, their agents, employees and successors in office, and all other persons in active concert and participation with them, from implementing the proposed reductions in the Medicaid program on August 15, 1980.

3. Declare that the defendants have violated the rights of the plaintiffs under 42 U.S.C. § 1396a, 29 U.S.C. §794, 42 U.S.C. § 2000d *et seq.* and the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States.

4. Declare that defendants Fowinkle and Crim have violated plaintiffs' rights under the Equal Protection Clause of the Fourteenth Amendment to the Constitution of the United States.

5. Preliminarily and permanently enjoin defendants from implementing the proposed reductions in the Medicaid program contained herein or from otherwise violating 42 U.S.C. § 1396a, 42 U.S.C. §2000 d *et seq.*, 29 U.S.C. § 794 and the Due Process and Equal Protection Clauses of the Fourteenth Amendment of the Constitution of the United States.

6. Provide reasonable attorneys fees as authorized by 42 U.S.C. § 1988 and 29 U.S.C. § 794a.

7. Grant plaintiffs such other relief as may be necessary and appropriate to serve their rights.

Respectfully submitted,

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Counsel for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

AMENDED COMPLAINT

Plaintiffs, pursuant to Rule 15(a) of the Federal Rules of Civil Procedure, amend their complaint by adding to the section entitled "Factual Allegations: I. Impending Cutbacks" the following paragraphs, to follow paragraph 35 and precede paragraph 36 of the original complaint:

35. (a). According to the affidavit of James E. Word, Deputy Commissioner of the Tennessee Department of Public Health, filed in this action on August 14, 1980, defendants will, effective August 16, 1980, reduce the number of inpatient hospital days covered by Medicaid from a current level of twenty days per fiscal year to a limit of fourteen days per calendar year. Defendants' intended policy makes no allowance for the medical necessity of inpatient hospital services being deleted from the Medicaid program. The defendants' proposed reduction in Medicaid coverage of inpatient hospital services was not included in the public notice posted in County offices of the Tennessee Department of Human Services (Attachment "C" to the original verified complaint) which notices

were incorporated in the legal notices published throughout the state on or about June 15, 1980. (Attached as Collective Exhibit "D" to the affidavit of James E. Word). The inpatient hospital days which are being deleted from Tennessee's Medicaid program are medically necessary, and the loss of such treatment will result in irreparable injury to the health and safety of members of the plaintiff class, many of whom have already exhausted their coverage for the current calendar year.

35. (b). The Tennessee state Medicaid plan required by 42 U.S.C. §§1396, 1396a, 1396b and 1396c has not, according to the affidavit of James E. Word, filed by the defendants August 14, 1980, been amended to reflect the changes in the amount, scope and duration of services and levels of provider reimbursement intended by the defendnats and challenged by plaintiffs herein. Tennessee's approved state Medicaid plan does not authorize the Medicaid cutbacks which the defendants intend to implement August 16, 1980.

Plaintiffs further amend the causes of action contained in the original complaint in the following manner:

1. The fifth cause of action, paragraph 59, is amended to add the following sentence: "The defendants' reduction of the number of inpatient hospital days covered by the Tennessee Medicaid program violates 42 U.S.C. 1396a and 42 C.F.R. §§440.230(b) and (c)(2), which require that services provided under the state plan be sufficient in amount, duration, and scope to reasonably achieve their purpose, and which provide that services may only be limited on the basis of medical necessity or utilization control procedures."

3. The eighth cause of action, paragraph 62, is amended to add the following sentences: "The defendants'

reduction of the number of inpatient hospital days covered by the Medicaid program discriminates against persons with certain conditions, in violation of 42 U.S.C. §1396a and 42 C.F.R. §440.230 (c)(1), which prohibit denial or reduction of services based on diagnosis, type of illness or condition."

4. A tenth cause of action, paragraph 64, is hereby added to the complaint and reads as follows:

64. Defendants' reduction of the amount, scope and duration of services, and of levels of provider reimbursement, provided under the Tennessee Medicaid program places the state's administration of the Medicaid program in conflict with its existing approved state Medicaid plan. The changes which defendants intend to implement have not been incorporated in state Medicaid plan amendments which have been fully reviewed by the Secretary of Health and Human Services and approved by her following a determination of their conformity with federal law and policy. Defendants' intended cutbacks in the Tennessee Medicaid Program therefore violate 42 U.S.C. §1396 and 1396c as well as 42 C.F.R. §205.5(a).

5. An eleventh cause of action, paragraph 65, is hereby added to the complaint and reads as follows:

65. Defendants' reduction of Medicaid coverage for inpatient hospital services, in conflict with prior public notices affirmatively representing that no such cutbacks would be made, violated 42 C.F.R. §447.205.

Plaintiffs further amend that section of their original complaint which is captioned "Relief Requested" by deleting paragraphs three and five of that section (page 23 of the complaint) and substituting therefore the following paragraphs:

3. Declare that the defendants have violated the rights of the plaintiffs under 42 U.S.C. §§1396 et seq., 29 U.S.C. §794, 42 U.S.C. §2000d et seq., and federal regulations promulgated pursuant to these statutes, and the Fourteenth Amendment to the Constitution of the United States.

4. ...

5. Preliminarily and permanently enjoin defendants from implementing the proposed reductions in the Medicaid program complained of herein, or any other reductions prior to review and approval by the Secretary of an amendment to the state Medicaid plan, or from otherwise violating 42 U.S.C. §1396, et seq., 42 U.S.C. §2000d et seq., 29 U.S.C. §794, and federal regulations promulgated pursuant to these statutes, as well as the due process and equal protection clauses of the Fourteenth Amendment of the Constitution of the United States.

The remainder of the original complaint not explicitly deleted herein, is hereby incorporated herein by reference as fully as if set forth verbatim.

Respectfully submitted,

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COUNSEL FOR PLAINTIFFS

(CERTIFICATE OF SERVICE OMITTED IN PRINTING)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

ANSWER OF THE DEFENDANTS LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, EUGENE W. FOWINKLE, M.D., IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH AND BEN CRIM, IN HIS OFFICIAL CAPACITY AS ASSISTANT COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH

Defendants Alexander, Fowinkle and Crim in their official capacities, respond to the original and amended complaint of the plaintiffs, paragraph by paragraph, as follows:

1. *First Sentence.* Admitted.

   Second Sentence. Admitted.

   Third Sentence. Admitted.

2. Admitted.

3. *First Sentence.* Denied.
Second Sentence. Denied.

Third Sentence. Admitted.

Fourth Sentence. Denied. The Governor of the State of Tennessee is responsible only for appointing members of the Medical Care Advisory Committee. The establishment and composition of the committee is the responsibility of the Commissioner of the Tennessee Department of Public Health.

4. Admitted.

5. Admitted.

6. Admitted.

7. Admitted.

8. *First Sentence.* Admitted.

Second Sentence. Admitted to the extent that the Department of Human Services is responsible for conducting fair hearings on grievances pertaining to Medicaid "eligibility."

Third Sentence. Admitted to the extent that each county director is responsible for assuring that hearings are provided with respect to Medicaid "eligiblity."

Fourth Sentence. Admitted.

9. Plaintiffs admit that the defendants seek class action certification as stated in paragraph 9 but deny that said class certification is appropriate.

10. Defendants deny that plaintiffs have met the prerequisites for class certification as set forth in paragraph 10.

11. Denied. The relief that plaintiffs seek in their complaint can be granted by the Court irrespective of whether the class certification requested by plaintiffs is granted.

12. Denied.

13. Admitted.

14. Admitted.

15. Admitted.

16. Admitted.

17. Admitted.

18. Defendants admit the allegations contained in paragraph 18 and, in addition, state that the intermediate care nursing home services are also an "optional" service of the Medicaid program.

19. Admitted.

20. Admitted.

21. Admitted to the extent that "claims for Medicaid coverage" constitute claims for services submitted by medical care providers who have rendered service to Medicaid recipients.

22. *First Sentence.* Defendants admit that on or about July 1, 1980 the notice set out in Attachment A was sent to all of the approximately 300,000 Medicaid recipients in the State of Tennessee.

Second Sentence. Admitted.

23. *First Sentence.* Admitted.

Second Sentence. Admitted.

Third Sentence. Admitted.

24. The defendants are without knowledge or information sufficient to form a belief as to the truth or validity of the allegations contained in paragraph 24.

25. Admitted.

26. *First Sentence.* The defendants are without knowledge or information sufficient to form a belief as to whether Margaret Betty Baldwin in fact received the notice attached to plaintiffs' complaint as Attachment A.

Second Sentence. Denied.

27. *First Sentence.* Defendants admit that on or about July 28, 1980 the Tennessee Department of Public Health mailed proposed rule changes to county offices of the Tennessee Department of Human Services which are set out in Exhibit C to plaintiffs' complaint.

Second Sentence. Admitted.

Third Sentence. Denied.

28. *First Sentence.* Admitted.

Second Sentence. Denied.

29. *First Sentence.* Admitted.

Second Sentence. Denied.

30. *First Sentence.* The defendants deny that the proposed reductions in services and levels of reimbursement racially discriminate against the defendants or the class which they proportedly represent.

Second Sentence. The defendants admit that the statistical report cited in the second sentence of paragraph 30 accurately reflects money spent by the Medicaid program during the fiscal year 1978. The defendants are unable to admit or deny the ambiguous allegation that the "health status of blacks is generally poorer that that of whites" without further specificity as to the meaning plaintiffs give this phrase.

31. *First Sentence.* Denied.

Second Sentence. Denied.

Third Sentence. Defendants are unable to answer the third sentence of paragraph 31 in that plaintiffs fail to state for which time period said percentages apply.

Fourth Sentence. Defendants are unable to answer the fourth sentence to paragraph 31 in that plaintiffs fail to state for which time period said percentages apply.

Fifth Sentence. Denied.

Sixth Sentence. Denied.

32. *First Sentence.* Defendants admit that certain drugs heretofore available under the Medicaid program will be deleted under proposed reductions.

Second Sentence. Denied.

33. *First Sentence.* Denied.

Second Sentence. Denied.

Third Sentence. Denied.

Fourth Sentence. Defendants are unable to answer the fourth sentence of paragraph 33 in that plaintiffs fail to state the source of statistical conclusions drawn.

Fifth Sentence. Defendants are unable to respond to the fifth sentence of paragraph 33 in that plaintiffs fail to cite the precise statistics mentioned.

34. Denied.

35. Denied.

36 - 50. The defendants admit that all the named individuals in paragraphs 36-50 are presently eligible for Medicaid benefits and have in the past received said benefits. The only manner in which the defendants can respond to the allegations regarding

the medical conditions of the individual plaintiffs and their required medical care, is to determine what services have been rendered to them under the Medicaid program. This can only be done by retrieving such data from the computer system of EDS Federal Corporation as to claims submitted by providers of plaintiffs medical care. The defendants at the present time are in the process of retrieving said data and upon completion thereof will answer paragraphs 36-50. At the present time, however, the defendants are without knowledge or information sufficient to form a belief as to the truth or validity of all the allegations contained in paragraphs 36-50.

51. Denied.

52. *First Sentence.* Admitted.

Second Sentence. Admitted.

Third Sentence. Admitted.

53. Denied.

54. Admitted.

55. Denied.

56. Admitted.

57. Denied.

58. Denied.

59. Denied.

60. Denied.

61. Denied.

62. Denied.

63. Denied.

The defendants further respond to plaintiffs' first amended complaint, paragraph by paragraph, as follows:

35(a). *First Sentence.* Admitted.

Second Sentence. Denied.

Third Sentence. Admitted.

Fourth Sentence. Admitted.

Fifth Sentence. Denied.

35(b). Defendants admit that the presently approved Medicaid plan does not reflect the proposed reductions. Said proposed changes, however, have been formally submitted to the U.S. Department of Health and Human Services in accordance with procedures established and followed by the Department since Tennessee first participated in the Medicaid program in 1969.

59. *Additional Sentence.* Denied.

61. *Additional Sentence.* Denied.

62. *Additional Sentence.* Denied.

64. *(A New Paragraph).* Denied.

65. *(A New Paragraph).* Denied.

WHEREFORE, the aforementioned named defendants in their official capacity, having fully responded to plaintiffs' complaint, respectfully request that said complaint be dismissed and that judgment be rendered in their favor.

Respectfully submitted,

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(CERTIFICATE OF SERVICE OMITTED IN PRINTING)

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043-NE-CV

Rosier Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, et al.,
Defendants.

STIPULATION OF FACTS

Counsel for the parties in this cause hereby stipulates that the following facts are true and need not be proven at trial:

1. Since August 15, 1980, defendants have given individual written notice to all providers and recipients of Medicaid services that previously announced reductions in the Tennessee Medicaid program have been suspended and will not be implemented pending further notice. No contrary notice has been published in any newspaper of general circulation or forwarded to either providers or recipients, since August 15, 1980.

2. Prior to implementing any reduction in the amount, scope or duration of services to be covered by the Tennessee Medicaid program, the defendants will send to all Tennessee Medicaid recipients individual written notices specifying which cuts are to take effect, and specifying the hearing rights, if any, which recipients may have to challenge the intended reductions.

3. The defendants have not received either written or oral federal approval of proposed state Medicaid plan amendments incorporating the Medicaid reductions which are the subject of this litigation.

The Office for Civil Rights for the Department of Health and Human Services (OCR) is currently reviewing the proposed

amendments for their compliance with *inter alia*, Section 504 of the Rehabilitation Act of 1973, and regulations promulgated thereunder. OCR, in furtherance of this review has submitted to the defendants a request for certain data pertaining to the impact on handicapped recipients of the proposed Medicaid cutbacks. The defendants have provided part, but not all, of the information sought by OCR as a basis for determination of the proposed state plan amendments compliance with Section 504.

4. On January 30, 1981, the Tennessee Medical Care Advisory Committee (MCAC) completed its review of the proposed cuts in the Tennessee Medicaid program. The committee recommended against implementation of some formulary reductions, and against a reduction in the number of covered days of inpatient hospital care. The defendants have received and considered the Committee's written reports and recommendations.

5. The parties stipulate that the affidavits filed by the parties in support of, or in opposition to, the granting of preliminary injunctive relief shall, with the exception of affidavits of expert medical witnesses whose depositions are offered in evidence, be received as evidence in the trial of this case. The parties further stipulate to the qualification as expert witnesses of all licensed physicians giving oral or affidavit testimony in this case.

6. Defendants have proposed to delete several hundred drugs from the formulary of prescription medications provided to eligible receipients under Tennessee's Medicaid program. Of these proposed deletions, plaintiffs challenge only the proposal to delete Medicaid coverage of the following drugs for any use:

a. Oral hematinics

b. Oral anti-histamines

c. Benzodyazapines

7. A reduction of Medicaid coverage of inpatient hospital days from twenty (20) to fourteen (14) days per year would result in a savings of approximately ten percent (10%) of that portion of the Medicaid budget attributable to inpatient services.

8. All figures used or developed by the defendants to measure the impact of the proposed Medicaid cutbacks upon handicapped patients have defined as "handicapped" only those patients who have been determined to be "blind" or "disabled" within the meaning of 42 U.S.C. §1382c(a)(2),(3) which defines eligibility for Supplemental Security Income (SSI) benefits under the Social Security Act. The parties further stipulate that SSI recipients are classified as "aged" whether or not they are blind or disabled when they reach the age of sixty-five.

9. Due to the reporting practices of hospital providers, there is no information available to the parties regarding the relative rates of utilization of exactly twenty days of inpatient hospital services by handicapped versus non-handicapped Medicaid patients. (The statistical data available to, and maintained by, the defendants lumps users of twenty (20) days of hospital care together with all users of any amount in excess of twenty days.) However, the parties do not have any information that would indicate that patterns of patient utilization of twenty days coverage per year differ significantly from patterns of utilization of fifteen to nineteen (15-19) days of hospitalization per year.

10. In connection with the defendants' weighing of alternative methods of reducing the cost of the Tennessee Medicaid program, Tennessee Medicaid personnel generated no memoranda, reports or other written information pertaining to methods used by other states to control Medicaid costs without compromising program services.

DATED this 16th day of February, 1981.

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043-NE-CV

Rosier Jennings, et al.,

Plaintiffs,

v.

Lamar Alexander et al.,

Defendants.

SUPPLEMENTAL STIPULATION OF FACTS

Counsel for the parties in this cause hereby supplement the stipulation of facts entered into on February 16, 1981 and agree that the following facts are true and need not be proven at trial.

12. The Tennessee Department of Human Services is responsible for enforcement of Section 504 of the Rehabilitation Act of 1973 with regard to the receipt, investigation, disposition and compilation of complaints from Medicaid recipients alleging discrimination against the handicapped in connection with the administration of Tennessee's Medicaid program. Such complaints are commingled by the Department of Human Services and filed with all other unrelated Medicaid recipient requests for administrative review of program decisions or practices. Recipient requests for administrative review on all matters, including discrimination allegations, total several thousand per year. Allegations of Section 504 violations are not separately indexed. For this reason, retrieval and review of recipient complaints of discrimination, though possible, are not feasible.

13. The defendants have not performed any written self-evaluations of their compliance with Section 504 of the Rehabilitation Act of 1973 in their administration of the Tennessee Medicaid program.

(Signatures of counsel omitted in printing.)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend, Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of Tennessee, et al.,
Defendants.

**PRELIMINARY INJUNCTION HEARING,
AUGUST 15, 1980**

TESTIMONY OF JAMES E. WORD

[Transcript of Proceedings, pp. 63-65, 90-91 and 97-98]

Direct Examination

By Mr. Scanlon:

Q. Mr. Word, you are a deputy commissioner of the Tennessee Department of Public Health; is that correct?

A. That is correct.

Q. How long have you been employed by the Department of Public Health?

A. July, 1969, eleven years.

Q. What was one of the major reasons you were first employed by the Tennessee Department of Public Health in 1969?

A. Commissioner Fowinkle employed me in 1969 with one of the major purposes to implement the Tennessee Medicaid Program.

Q. Since 1969, have you had general oversight and responsibility for the Medicaid program in the state of Tennessee?

A. Yes, I have.

Q. Mr. Word, just a few preliminary things before we get into the exact changes in the program. There has been a lot of discussion about there being cuts and cut-backs in the Medicaid program. Is the budget for this coming fiscal year for the Tennessee Medicaid Program, is that more or less money that had been spent on the program last year?

A. The Legislature has authorized for program services, and nursing home care, $388 million dollars, $26 million dollars above what was authorized last year for the program services and nursing home care.

Q. What is the reason that we are at the position where certain changes, reductions in program services, have to be made in level of reimbursement, since there was an increase in funding by the General Assembly, why are we still in the position to make these changes?

A. The Medicaid program, if it were to be continued at the 1979-80 level, in the area of program services and nursing home care was projected to cost the state and federal government, projected cost, $430 million dollars. It was the determination during the budget process by the executive branch and the legislative branch that $388 million dollars would be authorized. So it was incumbent upon the department to limit the growth of Medicaid to the $26 million dollars plus $42 million dollars which would have been to carry it to 1979-80 level or $68 million dollars.

Q. Mr. Word, when you first came to the state of Tennessee, what was the budgeted Medicaid program for the first year of its operation, do you recall?

A. As I recall roughly for the first year of Medicaid, we implemented, I believe, in October of 1969, the first year expenditures were $17 million dollars.

• • •

Q. Mr. Word, the final areas of the cut-backs in the program that I wish to discuss is the hospital in-patient days. Is hospital in-patient care required under the Medicaid program?

A. Yes, it is.

Q. Now, prior to the change to be effective tomorrow, how many days per year did the Medicaid program pay recipients for hospital care?

A. We paid for between, and I might add as an aside, Judge, your question awhile ago on how we arrived at that, the number 20 again was a subjective number chosen in 1969, and it's been 20 ever since 1969.

Q. You are reducing now to 14, is that correct?

A. Yes, that is our intent.

Q. Do you have any idea—I believe you gave a figure up here a little while ago, Your Honor, with respect to percentage of impact and Mr. Word corrected me. I'll ask the question now. Have you arrived at any kind of ideas what impact this will have on Medicaid recipients by going back 14 days as opposed to 20?

A. If we pay for 14 days of in-patient hospitalization, we'll pay for the number of hospital days that are required by 90 percent of the recipients.

Q. Is this for a particular year you did this?

A. This is for fiscal year 1978-79.

Q. Are you saying then that in that year 90 percent of the Medicaid recipients used 14 days or less on the program, is that correct?

A. That is correct.

Q. During that year they could have gone to 20, is that correct?

A. That is correct.

Q. They didn't use them all up?

A. Right. And it's our opinion that again meets the federal requirement of amount, duration and scope.

• • •

Q. Am I correct that you made a decision sometime before August 1st not to reduce the number of in-hospital days?

A. At the time we issued the original public notice, we had not made a decision. A tentative decision was made before August 1st that it would not be necessary to reduce in-patient hospital days in order to get the forty-eight and a half million dollars. We were advised on August 1st that in fact we could not make the change in the method of reimbursement to hospitals. Later in that week we did—well, really, later in this week, we did reconsider whether or not we were going to reduce from 20 to 14 days, and there was a decision to reduce it.

Q. But am I correct, is it a fair statement that you all decided you weren't going to do that, and the Atlanta office of HEW told you you couldn't put that cut into effect without prior approval?

A. Which cut are you referring to?

Q. The cut in hospital reimbursement.

A. The reduction method?

Q. Yes.

A. The Atlanta office, on August 1st, in a letter from Richard Morris, advised us we had to have prior approval. That's all

they advised. Had to be prior approval before it could be implemented.

Q. Am I correct the only thing at that point you had submitted to Atlanta was, in writing, was a request to approve the change?

A. We had submitted nothing to Atlanta in writing at that point.

Q. What prompted that letter from Mr. Morris?

A. You'll have to ask Mr. Morris that question.

Q. You were at that point it was the letter from Mr. Morris, though, that prompted your decision to go to the hospital inpatient day limitation on coverage?

A. That, and during the public hearing, we were repeatedly hearing from the—at least from providers that they would rather have the number of days reduced than they would to tamper with the method. Those two things, yes, did prompt that decision.

Q. Anything else that prompted that decision other than what you outlined?

A. Not that I know of.

Q. You at no time received any approval from Atlanta to implement these proposed reductions?

A. We have at no time received—we have at no time received any approval or denial. We did not submit it until August 13th, and we had no communication....

• • •

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend, Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF ELEANORE MOORES

[Transcript of Proceedings, pp. 10-25]

Direct Examination

By Miss Garner:

Q. Miss Moores, I'm going to read a statement that summarizes your background information and I'd like you to listen to it carefully and tell me if it is correct.

You reside at 3416 Murphy Road, Nashville, Tennessee. Are a social worker on the staff of Veterans Administration Hospital in Nashville. You'll be testifying today as an individual and not in connection with the VA Hospital. You received a Bachelor of Science Degree in sociology and psychology and have a Master of Social Work Degree, certified by the National Association of Social Workers.

Your employment experience has included a position with the Department of Mental Health in Alabama, Medical Outpatient Clinic, Vanderbilt Hospital, and Kidney Dialysis and Transplantation, Vanderbilt Hospital, and Veterans Administration Hospital. Your responsibilities as social worker

have been to obtain admission for patients without ability to pay, particularly kidney dialysis and transplant patients.

As a social worker at Vanderbilt Hospital from September, 1977, until October, 1979, you had opportunity to observe the hospital admission practices, and the difficulties encountered by indigent and Medicaid-eligible patients in securing admission to the hospital; is that correct?

A. That is correct.

Q. Miss Moores, please describe the policy and practice of Vanderbilt Hospital as you observed it with respect to persons unable to pay for hospital care.

THE COURT: Now, a little something there. She's connected with Veterans Administration Hospital by an arrangement between Veterans Administration and Vanderbilt; is that correct?

WITNESS: I was formerly an employee of Vanderbilt Hospital.

THE COURT: For how long?

WITNESS: Two years.

THE COURT: What was this time limit?

WITNESS: September of '77 until the end of October, '79.

THE COURT: September of '77? All right. Thank you. Go ahead.

Q. (Miss Garner) Miss Moores, go ahead and describe the policy and practice of Vanderbilt Hospital as you observed it with respect to persons unable to pay for hospital care at Vanderbilt.

MR. SCANLON: Your Honor, I'd like to make clarification of the testimony here. The witness, I take it, is not testifying about the present practice?

THE COURT: She's testifying about '77 through '79, that's all she knows, unless she says she knows something different later on.

MR. SCANLON: Thank you, Your Honor.

THE COURT: Have to give the breakdown at that time.

WITNESS: Okay. The policy at the time I was employed at Vanderbilt was they did not turn away emergency admissions. This created a problem with, particularly with some of the kidney patients that we worked with who had no resources, because people with renal failure who will go on kidney machine, their condition will not ever go away, get well, but they continue to deteriorate. There comes a point in that time when a person is not technically an emergency, but when it's necessary that they come to the hospital for needed treatment, hopefully to prevent their ever becoming an emergency.

On more than one occasion we encountered the situation where a patient had absolutely no resources for hospitalization, and they had to be allowed to remain where they were, and deteriorate to emergency status before they could receive the needed medical care. We had one patient who went through this process twice. What this boils down to is that instead of a proposed and timely hospitalization of seven to eight days for initiation of dialysis, when these patients became emergencies, they then spent approximately thirty days in the hospital, the first five, six or seven of which were in intensive care, which is a more expensive proposition both in terms of money and the patient's well-being.

Q. (Miss Garner) Miss Moores, at the time you worked at Vanderbilt Hospital with the kidney dialysis and transplant patients, were there other facilities where they could get the necessary treatment for the kidney conditions?

A. Vanderbilt is a center as described under provisions of Medicare, and is the only center in Nashville. Peritoneal dialysis

is available at General. Hemodialysis, and peritoneal dialysis are both available at Vanderbilt. However, since it is a center, many people came from even other states or as far away as Knoxville in our state.

THE COURT: That is another state.

WITNESS: So that some of these patients would not have been eligible for admission to General, and General did not have the whole range of services available.

Q. Miss Moores, you described situations where a person's condition would be permitted to deteriorate until they were emergency patient and could be admitted to Vanderbilt. Did you ever see that phenomenon occur with persons who had exhausted their Medicaid coverage and therefore were not admitted to the hospital?

A. Yes, I did. The patient in particular that I referred to that went through this process twice was a person who when she became an emergency the first time, was admitted to Vanderbilt, and because of the expenses she was incurring at that time she qualified for the Medicaid spindown program which gives twenty days of hospitalization. She was in the hospital thirty days, and so she exhausted her entire year's allotment during that hospitalization and had ten days left over.

Then when she became an emergency again, there was no place to turn, because she had already exhausted her Medicaid, and so she had to allow—had to be allowed to become an emergency before she could be admitted to the hospital the second time.

Q. Mrs. Moores, during the time you worked at Vanderbilt, did you keep any documentation of these crises?

A. Only during one brief period when I was—I was so frustrated in trying to arrange hospitalization for patients like this who kept cropping up, and who had no resources, and over

the period, August 1st of '78 to about January of '79, I documented five patients, but there were six instances because one of these was the one I referred to this happened to twice. The purpose of gathering this data, these data, was to try to influence the policy at Vanderbilt in hopes that some arrangement could be made to admit these patients before they became emergencies.

Q. Were you successful in influencing administration policies of Vanderbilt Hospital?

A. No, I was not. In all fairness let me say that in going through the chain of command, my recommendations, I don't think, ever got out of my department. So I'm not sure that the arguments that I put forth ever reached decision makers at Vanderbilt.

Q. At the time you left Vanderbilt Hospital, these policies were as you stated they were here?

A. Right.

Q. Was the policy that you have described at Vanderbilt Hospital an across-the-board policy for all admissions to the hospital or did it pertain only to kidney patients you described?

A. Vanderbilt's policy across the board is they never turn away emergencies.

Q. Therefore, the phenomena that you described would occur in all instances; is that correct?

A. That could happen in many different cases, yes.

Q. When you were working at the medical outpatient clinic at Vanderbilt, did you observe the same phenomena?

A. We had some difficulty getting patients admitted for needed admissions at that time, too.

Q. What was Vanderbilt's policy and practice with respect to Medicaid recipients whose coverage was exhausted after they had been admitted and treatment had been instituted?

THE COURT: Put on Hill-Burton.

WITNESS: There comes a time when Vanderbilt's Hill-Burton commitment is satisified for that year, too, Your Honor.

THE COURT: We've been talking about that for four or five years. Go ahead.

WITNESS: So some of the patients I had were also caught in that situation, that when Vanderbilt has a stated amount per year they have to honor in terms of Hill-Burton, that can be exhausted in a few months. So that for some of the patients over this five month period I was talking about, that was part of the problem was that that recourse was not available.

Q. (Miss Garner) What action if any would Vanderbilt take for a patient who was not covered by Hill-Burton, or who had exhausted Hill-Burton availability, and also exhausted Medicaid coverage, once that person had been admitted and Medicaid coverage expired, what would Vanderbilt Hospital do?

A. If they were an emergency admission, they would admit them and then they would be billed.

THE COURT: Her question was, once you get them in there, you're stuck with them, all you can do is bill them; is that right?

WITNESS: Right.

THE COURT: You keep them?

WITNESS: Keep them.

Q. (Miss Garner) Miss Moores, did you experience any kind of pressure as a social worker to move patients to other hospitals or to nursing homes?

A. There was that pressure in the sense there is utilization review at the hospital, and whether the patients have coverage or not, there is some need to confine their stay to what is usual in light of what they are being treated for.

Q. But in general as you responded to the Court's question, Vanderbilt Hospital would make a medical decision about whether to keep the eprson; would not purely on a financial basis move them out of the hospital.

A. That is true.

MISS GARNER: Thank you.

THE COURT: Are you talking about two types of dialysis? I'm not—I want to know what type were you talking about?

WITNESS: The peritoneal may be different now, Your Honor, but at the time I was there, only peritoneal dialysis, which is a method of treatment by putting fluid in the abdomen and draining back in and out over a number of hours as opposed to what we think of usually when we think of kidney machine where blood access is treated.

THE COURT: That's clear. I just wanted to be educated.

Cross-Examination

By Mr. Scanlon:

Q. Miss Moores, I believe you testified that you did a study of your own during a brief period of time you were at Vanderbilt with respect to five patients that you've indicated had a problem of getting into the hospital, and I believe they were all kidney patients, is that correct?

A. That is correct.

Q. The problem, the reason they were having a problem getting into the hospital, they didn't have any money?

A. That's right.

Q. Now, if you would, I believe we did this the other day when we talked, let's run through those five individuals, and I believe you said one of them was a problem twice, if I recall. Could you go through those five individuals and tell us what happened to them?

A. All right. Two of those were Medicaid recipients whose days were exhausted. At that time there were some—still some Hill-Burton funds available. And we were able to—I was able to arrange a commitment of Hill-Burton funds before they were admitted, and was able to get those two patients into the hospital.

The third patient was a young man who was very close to emergency status. We could not arrange his hospitalization any other way, and so we were able to make referral through Vocational Rehabilitation which as you know is not designed to respond in an emergency. Took some four to five weeks to—for them to go through the usual process, and the doctors managed to maintain this patient just short of emergency status while Vocational Rehab did their investigation and picked up his case.

Q. When you say picked up his case, picked up his hospitalization?

A. Right. And they have to agree to that before the person comes into the hospital. It's not anything that can ever be arranged once the person is admitted.

Q. So that is three of the five. Would you describe the other two?

A. And the other two were those people who had no coverage of any kind who were in hospitals outside of Davidson County, where the needed treatment was not available, and whose doctors were in contact with our doctors trying to arrange for them to be admitted to Vanderbilt. We were not able to do that, and

both of these patients were those who had to be allowed to deteriorate until they met the criterion for an emergency admission.

Q. With respect to these two individuals, do you know if they were Medicaid recipients?

A. They were not at that time. Now, one of those was the woman that I—they became Medicaid recipients on the basis once they were admitted to the hospital, or once they accumulated a large enough medical expenses they qualified under the spindown provisions of Medicaid.

Q. So one of the individuals—with respect to this individual, as soon as she became eligible, Medicaid picked her up; is that correct?

A. Yes.

Q. But prior to the time that she had spindown resources under the medical unit program, she was not eligible for Medicaid?

A. That is correct.

Q. With respect to the other patient I believe that accounts for four individuals, with respect to the fifth individual, was this individual eligible for Medicaid?

A. Became eligible when she had incurred enough medical expenses.

Q. So she was the same as the other individual, is that correct?

A. Yes.

Q. So at that time these two individuals were unable to get into Vanderbilt Hospital, and they were not eligible for Medicaid at that time; is that correct?

A. That's right.

Q. Now, Mrs. Moore, you've given some description here today about the difficulty for a patient in getting into a facility, into a hospital without funds. Is there also a problem, based upon your experience in working at Vanderbilt, for individuals who are in the facility, Medicaid runs out, insurance runs out, or Hill-Burton runs out, is this a problem with patients?

A. How we are going to pay things is a problem for patients as well as it is for anyone else, yes.

Q. It's a problem for the hospital, too, isn't it?

A. Yes.

Q. The hospital administration I take it doesn't particularly like to have patients in the hospital who aren't paying.

A. Not if they can help it.

Q. What effect does this have upon the individual when the number of covered days, or their money, whatever, runs out, what effect does this have on them from a psychological point of view, based upon your experience?

A. Some people worry very much about their hospital bills and the amount of bill they're running up.

Q. Isn't it true as you told me the other day, that you've seen it reduce patients to jelly, isn't that what you told me?

A. Some people are very anxious, very responsive to that, yes.

Q. Is there an inclination on the part of people at times to want to leave the facility when the number of days runs out?

A. I have occasionally encountered that. I would not say that is across the board.

MR. SCANLON: Thank you, Miss Moores.

Redirect Examination

By Miss Garner:

Q. I have one further question for you. Can you describe the effect you have observed upon patients and their families when these people are trying to get admitted to the hospital but are not able to be admitted?

A. That is much worse than worrying about the hospital bills after they get in. You know, if you have a choice of worries, worrying about whether you're going to live long enough to get the treatment, I would think, would outweigh how you're going to pay the bill after you get it.

MISS GARNER: Thank you, Miss Moores.

(There being no further questions, the witness was excused.)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF JOHN GRANTIER

[Transcript of Proceedings, pp. 27-31]

Direct Examination

By Mr. Barrett:

Q. Mr. Grantier, you hold an A.B. degree in mathematics from Hamilton College achieved in 1958 and were employed from 1958 to 1967 with Mutual of Metropolitan, and from 1967 to 1974 with Minnesota Mutual Insurance Company, and from 1974 to date with Book and Company of Winston-Salem, North Carolina, most recently holding the position of vice president and senior actuary. You have been a fellow in the Society of Actuaries since 1971, and are a member of the American Academy of Actuaries and have been since 1970. Is all that correct?

A. Yes, sir.

Q. In the course of your employment with Minnesota Mutual

and more recently with Book, you had extensive experience with group insurance analysis.

A. Yes, sir, I have.

Q. In your employment for the last two and a half years, especially with Book, have you had extensive experience int eh analysis of health insurance products and projections?

A. Yes, I have.

Q. Would you read your testimony—

THE COURT: It's agreed to as read, and a copy will be furnished to the court reporter and she will incorporate it in the record at this point. Go ahead. I've read it, by the way, but I want it explained.

(Following is the "Summary of Expert Testimony of John Grantier."

"The cost of providing inpatient hospital services of Medicaid recipients with a limit on the number of days to be reimbursed per admission may be projected by an actuary in the same manner as one would project the cost of coverage of any health service for any group. The cost of inpatient hospital services with a per stay reimbursement limit would be the multiple of the rate of use of those services by recipients ("incidence rate") and the average cost of one inpatient stay ("average benefit").

The accuracy of the projection of the cost of providing inpatient services on the basis of a per stay limit would depend upon the accuracy and specificity of the data used by the actuary in formulating assumptions concerning the incidence rate and average benefit. The incidence rate (of recipient utilization of inpatient services) could be projected from the experiences of those states who provide inpatient services on a per stay limit basis. While this kind of data might need to be adjusted for such differences as climate and education and income levels for

recipients, data from neighboring states such as Virginia and Kentucky would provide a sound basis for an incidence rate projection. If comprehensive data on the rate of inpatient admissions were available for Tennessee recipients for a period of less than an entire year, a factor could be devised for allowance of seasonal variations in utilization.

Two factors would be essential to projecting the average benefit (or average cost per stay). The first of these is the average length of stay. Studies such as the Commission on Professional and Hospital Activities length of stay compilations for each region of the United States provide reliable data on which to base a projection. The second factor in projecting the average benefit is the average cost to the Medicaid program of a recipient day of inpatient services. A reliable projection would also take into account cost trend factors for hospital per kiem rates and hospital-based physicians' services. The projections of hospital costs and cost trends to be used in projecting the average benefit for a days-per-admission limit would be identical to those used in projecting the cost savings of a reduction in the number of days covered on a fiscal year basis.

I am confident that a reliable projection of the program cost of limiting reimbursement for inpatient services on a per admission rather than fiscal year basis could be projected from the data I have mentioned and other information generally available to actuaries could be made by a skilled actuary in approximately three working days.

By holding the utilization or incidence rate and per diem cost factirs as constants, and using the number of days to which Medicaid coverage would be limited for inpatient services (which will affect the average benefit) as a variable, projections would yield the number of days to which coverage could be limited to achieve costs within any projected budget.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF JAMES E. WORD

[Transcript of Proceedings, pp. 50-54, 59-62 and 66-69]

Direct Examination By Mr. Scanlon

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MR. SCANLON: I appreciate that, Your Honor. I would like, however, to call the witness's attention as a preliminary matter to one of the exhibits that has been filed by the defendants, and, Mr. Word, I call your attention to Defendant's Exhibit 2. (A-167)

THE COURT: You haven't filed that yet.

MR. SCANLON: Yes, Your Honor, I gave you a copy. Perhaps your clerk has it.

(Document passed to the Court.)

MR. SCANLON: If Your Honor would like to follow on yours, it's on page D-2 of that exhibit. [A-167]

Q. (Mr. Scanlon) Mr. Word, this document indicates the Medicaid expenditures, fiscal years 1975 through 1981, and with each year, fiscal year '75, fiscal year '76 and so on, there are three separate columns for each of the fiscal years. I believe you have that chart before you, sir.

With respect to the column—let's take fiscal year 1975 as an example, column indicates the number of users, then the next one indicates the number of eligibles. Could you tell us what those two categories are?

A. Number of eligibles are those people who are eligible for the program. You can see that it has remained virtually constant.

Q. Just identify the categories of eligibles, in other words, of number of people that have Medicaid cards issued to them.

A. That is correct. That is the number of people we mail Medicaid cards to.

Q. The column of users—

A. The people utilized Medicaid services, roughly forty-five percent.

Q. Pull their card out of their pocket when they go to the hospital to use it, is that correct, or for whatever medical services—

A. They are those who did use it in fiscal year 1975.

Q. The difference between what would be eligible and users accounted for, as I understand it, Mr. Word, and correct me if I'm wrong, many people automatically issued Medicaid cards, whether or not they need medical services, may never ever use the card; is that correct;

A. That is correct, there are certain categories that are eligible.

Q. The third column again for the year 1975, there is a figure. Is that a total dollar figure?

A. That's the total dollar figure, comprised of state and federal.

Q. And would you explain, this is total amount of money spent on the program, you say state and federal, could you for the record clarify that?

A. If you look at the first year, 1975, you'll see a hundred and thirty-six point seven million dollars spent, of that 37.7 million was state dollars, 98.9 was federal dollars. That reflects seventy percent federal participation and thirty percent state participation that we talked about before. That's reflected in each of the subsequent fiscal years.

Q. And for fiscal year 1981 on through, what is the fiscal year this represents, what does it run from, from what to what?

A. Runs from July 1st to June 30th, state fiscal year.

Q. So fiscal year 1981 would be the current fiscal year, is that correct?

A. That is correct.

Q. If you could, Mr. Word, looking at the number of users on the Medicaid program over the years, would it be fair to say in your opinion the number of users remain somewhat constant?

A. It has fluctuated somewhat, but it has remained virtually—virtually constant, no dramatic changes.

Q. Would that be a fair characterization of the number of eligibles on the Medicaid program?

A. That is a fair characterization of the number of eligibles, right.

Q. With respect to cost, Mr. Word, how does that chart look with respect to costs?

A. It's obvious, beginning back in 1979, and as this chart reflects from '75 forward, the cost has dramatically gone up from in '75 136.7 million to projection in fiscal year '80-81 to 430 million.

Q. Basically, Mr. Word, in the last, oh, six fiscal years, seven fiscal years, what is reflected on the chart, the Tennessee Medicaid program has in fact served the same number of individuals, but the cost has been dramatically increased?

A. My one sentence analysis of that chart is that recipients are using more units of service at a higher cost.

THE COURT: It's interesting from 1979, '80, '81, it went up about forty—from that time went up about 40 million a year, roughly.

WITNESS: Yes, it seems to run about twenty percent.

* * *

Q. Mr. Word, we were in Court here in August in preliminary injunction hearing at which time the State of Tennessee was attempting to implement numerous changes in the Tennessee Medicaid program, and could you indicate for us the reason why back in August, to bring everybody up to date, why those changes were proposed?

A. We proposed changes in the Medicaid program in this fiscal year because there was a 388 million dollar appropriation for program services for nursing home care.

We analyzed early in the fiscal year that the program at its current expenditure level and current scope of services would expend 430 million dollars. And as you can see, there is a 42 million dollar difference.

We proposed, went through rule-making, attempted to make changes in the Medicaid program to reduce it by 42 million dollars or to reduce the growth by 42 million dollars and stay within the appropriation.

Q. Now, Mr. Word, at the present time, it's the month of February, as I understand it, none of these changes have been implemented; is that correct?

A. That is correct.

Q. Does the Tennessee Department of Public Health still desire to implement all of these changes that it proposed back in August?

A. With the exception of three that we have withdrawn, we would like to implement the rest.

* * *

Q. (Mr. Scanlon) Mr. Word, let's move specifically now to the area of in-patient hospital change in the program.

THE COURT: That's 20 to 12 days.

MR. SCANLON: Twenty to 14, Your Honor.

THE COURT: Okay.

Q. (Mr. Scanlon) Mr. Word, what is the Medicaid program presently spending a year—let's pick whatever fiscal year you have figured for, indicate the cost of the in-patient hospital—

THE COURT: Let me—can I interpose a question, not an objection?

MR. SCANLON: Yes, sir.

THE COURT: Can you tell me why 20 days was picked originally? I may have known and forgotten if I did.

MR. SCANLON: Your Honor, to be quite candid, I participated in that discussion, and as far as I know, had no scientific basis.

THE COURT: No magic to it?

MR. SCANLON: No.

THE COURT: Did the federal government have 20 days as a suggestion?

WITNESS: They approved the 20 days in our state plan.

THE COURT: No, that's not quite the same.

WITNESS: I'm sorry, I didn't understand.

THE COURT: Did they have a requirement for 20 days?

WITNESS: No, they did not require it.

THE COURT: What is the normal—is there an average, is there—when you look at the various states who participate, do they have an average of 20 days, do a lot of them have 20 days, or do you know?

WITNESS: Yes, sir, in looking at the other states, I'll give you my opinion of that, my opinion of that is in looking at other states by and large the 20 days in-patient hospitalization would be conservative compared to other states.

THE COURT: What does that mean?

WITNESS: That means most states have either different method of doing it or they have more days. Some are unlimited like for example, Maryland has unlimited. There are some states who control the—particularly control length of stay by diagnosis. There are some states, one state proposed to give recipients ten in-patient hospital days every six months. So there are a variety of ways of doing it.

THE COURT: No uniformity in practice or prescribed by the Federal Government?

WITNESS: No, sir.

THE COURT: In the grant program.

WITNESS: No. The only uniformity in my opinion prescribed is uniformity relative to method of reimbursement, not how many days the recipients have.

* * *

Q. (Mr. Scanlon) Mr. Word, could you please indicate to us why the State of Tennessee desired to reduce the number of days from 20 to 14, was there any reason other than trying to save some money?

A. There was no reason other than fiscal constraints, needed to save money.

Q. Was there anything magical about 14, 13 or 15? It was simply 14 is where the money was, is that correct?

THE COURT: Had to save so much money, so many days, so much money, is that correct?

WITNESS: That's how the fourteen was chosen. In fact, after the fourteen was chosen, before it was ultimately decided on, we looked at certain information relative to who we served fourteen days. And you are right, how that number was chosen was backed into.

Q. (Mr. Scanlon) Could you project the savings to the Medicaid program if the program were allowed to reduce the cap on its in-patient days from 20 to 14, what the savings to the program would be for the fiscal year 1981-82?

A. Realizing this is a projection, Judge, we had estimated approximately 13 million dollars by the reduction from 20 days, currently down to the 14 days maximum level.

Q. This is roughly a ten percent saving, is that correct?

A. Yes.

Q. Now, in addition to reducing the number of in-patient hospital days from 20 to 14, does the Department wish to deal with the cost of hospitals in any other way, just look to reducing the number of days or try to save some costs elsewhere?

A. There were three other items that we proposed. One was application of third party benefits so that the state would get credit for the third party benefits the recipients might have and save about a million and a half dollars.

THE COURT: You're talking about Hill-Burton, private insurance?

WITNESS: Talking about predominantly, Your Honor, about private insurance.

THE COURT: Save about how much?

WITNESS: 1.5 million.

Q. (Mr. Scanlon) Mr. Word, just to make it clear for the Judge, the program now does apply private insurance, and the change would be the methodology which it is administered, and this is where the savings would come.

A. That is correct. What is essentially would do is say that regardless of whether you have third party insurance or what, everybody got twenty days. As it is at the moment, Medicaid recipients with insurance, get the twenty days plus however much insurance pays for.

We have, Your Honor, a directive from the Federal Government that we are out of compliance because we have not—we have not instituted this applicable—what I'm calling application of third party. They are saying everybody should get twenty days, even if they have third party insurance or whatever. We

haven't implemented that, but we have been directed by the Federal Government that we are out of compliance.

Q. Now, you said three other things. What are the other two that you wanted to do in addition to reduction?

A. Second was limitation on Friday, Saturday admissions, so those admissions would occur only in emergencies and only when surgery was on the day following. That was roughly three—approximately $300,000.00 to be saved in that one.

I mention that, the third one is that we were going to amend our method of reimbursing hospitals, piace a penalty on hospitals with vacancies, vacancies below ninety percent. That when we were told that we had to have prior approval on that one, that's a thirteen—that would have saved 13 million dollars, that's the one that we dropped and traded off to do the reduction in days.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend, Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF WILLIAM B. SHAW

[Transcript of Proceedings, pp. 76-109]

Direct Examination

By Mr. Scanlon:

Q. Mr. Shaw, for the record, please tell us where you live and where you are employed and in what capacity.

A. I live in Nashville, Tennessee. I'm Program Director for EDS Federal in Nashville. We are the fiscal agent, contractor to the State of Tennessee.

THE COURT: What are you program director of?

WITNESS: Program Director of EDS Federal, that's Electronic Data Systems Federal, which is a private corporation. We are a contractor to the State of Tennessee. We process the claims for the Medicaid program, using benefit outlines given to us by the state.

Q. (Mr. Scanlon) Mr. Shaw, you did not formulate any policy for Tennessee Medicaid program; is that correct?

A. We do not.

Q. Basically the system that you utilized to process claims is a computerized system; is that correct?

A. Yes, it is a computerized system.

Q. Mr. Shaw, throughout the course of the last several months, have you been requested by the Department of Public Health to call upon the data you have available to you through the claim processing system to put together some charts and summaries with respect to some of the changes proposed changes in the Medicaid program?

A. That is correct.

Q. Mr. Shaw, if you would, please, I call your attention to Defendant's Exhibit No. 4-A—[A-170]

(Passed to witness.)

That would be headed at the top, I believe, "Table 1," [A-170] is that correct, Mr. Shaw?

A. Yes.

Q. Now, with respect to Table No. 1 [A-170], was this prepared by your firm?

A. Yes, Table 1 was prepared by us.

Q. Was it prepared either by you or under your direction?

A. It was prepared under my direction.

Q. Could you tell us the source of the data and the years that it covers?

A. The data in Table 1 [A-170] is taken from paid claims from the service year of fiscal year '79 and '80, so it's beginning July 1, 1979, and ending June 30, 1980, service dates.

Q. And you said by paid claims, could you explain maybe that a little bit for the Judge?

A. This data is based upon claims that have been paid by the Medicaid program.

Q. I believe the terminology used, you scan those claims, and on the computer brought forth this data.

A. Yes, we selected all those claims and accumulated the data for this report.

Q. Now, if you would, Mr. Shaw, if you would, take and go through the first column on Table No. 1 [A-170], number of days utilized, and indicate what that represents.

A. Number of days utilized is just—it's what it says, it's the number of days utilized by a recipient.

Q. So in other words, between the parameters zero through twenty; is that correct?

A. Yes.

Q. Then it's broken down going across the top, medically needy, categorically needy, those are the categories of recipients of Medicaid?

A. Those categories for all recipients.

Q. The total would be the next column?

A. That is correct.

Q. Example of the Medicaid people who are eligible, who actually used Medicaid for in-patient hospital services for two days, that total would be what, Mr. Shaw, if you could identify it?

A. 8,989 used Medicaid, recipients who used two days.

Q. This would go all down the line from up to the 20 day period, is that correct, up through the 20 days?

A. That is correct.

Q. Now, I call your attention to—

THE COURT: Now, I think I understand this, but I want to be sure. On those that stayed 15 days, you have 565, that 565 is not added into any of these other figures?

WITNESS: It's not added in, it's unduplicated.

THE COURT: Unduplicated. All right.

MR. SCANLON: Your Honor, under the total at 15 would be all the way over at 685, that would be—

THE COURT: Yes, I understand, just using the first figure.

Q. (Mr. Scanlon) Mr. Shaw, get down to the 20 days, it's what we commonly refer to as the ballooning effect, at the 20 day, could you explain the figures at day 20, why they are so much greater than the other days?

A. At day 20 you will note there are 4,273 users in the total column. Actually that balloon is created there because of the current cap at 20 days. Providers of service have billed for twenty days to the program. The remainder of the days of those stays are not shown to the program, so that's why we show a large number of users at 20 days.

THE COURT: Say that again. There is a cap of 20 days—

WITNESS: There is a cap of 20 days. For example, Your Honor, note 19 days you have 495 users.

THE COURT: But you are saying accumulate 20 days, those 20 days, 21, 25, 30 days.

WITNESS: That is correct.

THE COURT: All right.

Q. (Mr. Scanlon) Mr. Shaw, I believe there was some testimony earlier by Mr. Word, to clarify the record, does the

Tennessee Medicaid program or your corporation specifically keep track of the number of recipients who, even though we only pay—the program paid for 20 days, were actually in the hospital for 21, 25 or 30, in other words, if you were to graph it on out, these people at 20 days, would you be able to tell us how many people Medicaid recipients only 20 days were paid for, but were in the hospital 25 days?

A. No, we can't. There is a place to provide that information on the claim form that went in, began use December 1st, 1979, but it is not required that the hospital give us that information. Some do, some do not.

THE COURT: Well, now, I don't know if this is going to be particularly important. Would you tell me on line 14 when you say accumulated users effective, you're talking about—and you have 7279, is that the total or is that something—what does that mean?

WITNESS: Well, Your Honor, what that means is that that says if you were to limit the day coverage at 14, you would be affecting a total of 7,279, and that's arrived at by adding from your total column, the bottom there, you have 4273 people it would affect, you have 495, 534 and so forth, those numbers are accumulated by adding back up to get 7279. So these are the total number of people that would be affected by a change from 20.

THE COURT: Those numbers are accumulated.

WITNESS: They are accumulated, cumulative users effective,—we took the 4273 and we added in at 19 days you have 495 people, so we added those in to give 4768.

THE COURT: I'm with you.

Q. (Mr. Scanlon) Mr. Shaw, moving on over to the percentage of users served, if you could explain that column.

A. The percentage of users served was derived at by taking the cumulative users affected column, and you are applying the formula given below that, percent of users served equals total users minus the cumulative affected users over total users. One thing there I need to mention, if the bottom grand total users also included Medicare-Medicaid patients, patients who have coverage under Medicare-Medicaid program, we applied that formula to the cumulative users affected to give the percentage shown in the right-hand column.

Q. With respect to the Medicaid-Medicare user, it might be good to at this point to explain that a little. I had some testimony Mr. Word brought out, going to be summarized, what is Medicaid-Medicare users, I see backed into those figures some 47,051 recipients.

A. This is again unduplicated from the 51,000 number. These are people who have in-patient coverage under the Medicare program. They also have Medicaid coverage and Medicaid does cover deductible—deductible they incur under the Medicare program.

THE COURT: So you are actually talking about deductible, that's all as far as the Medicaid program.

WITNESS: We pay the deductible.

THE COURT: Deductible is what?

WITNESS: Currently $180.00.

Q. (Mr. Scanlon) Just to make sure the record is clear, is that for these Medicaid-Medicare individuas Medicaid will pay for numerous other services that aren't covered by Medicare, is that correct, Mr. Shaw?

A. Yes, since they have Medicaid coverage they are getting other services Medicare does not provide.

THE COURT: I understand.

Q. (Mr. Scanlon) So if you would, explain then the significance of the column that says, percentage of users served with relation to number of days column.

A. What this shows following this through then, shows for each line, if the program were to be limited at any of those points shown, 14, 15, 16, shows you what percentage of the people would be served.

Q. So in other words, Mr. Shaw, if the program were during the fiscal year 1979, had had a limitation of 14 days, then is it a fair statement to say from your data that 92.56 percent of all the Medicaid in-patient hospital users would have been covered?

A. That is correct.

Q. Mr. Shaw, I call your attention now to—unless Your Honor has any more questions on that chart—

I call your attention to Table No. D-4-C, [A-172] that's skipping one over with respect to minorities, unless Your Honor wants to—Table No. 2 [A-171], Your Honor, simply separates out the data with respect to minorities, but I believe it's been blocked from the lawsuit. I'd like to go to the handicapped table, No. 3, D-4-C, [A-171] Table No. 3, Mr. Shaw, if you could explain what this table is in relationship to Table No. 1. [A-170]

A. Table 3 [A-172] parallels in methodology what we just looked at in Table 1, only it has taken just that group of people identified as handicapped.

THE COURT: Wait a minute, now. Okay, go ahead.

A. (Witness) Got the percentage in the middle on this one. What we did, we took again and arranged the days from zero to twenty, combined zero to thirteen into one line for purpose of simplicity, and then identified unduplicated count of our disabled, blind users. Coming over to the center column with total handicapped users again unduplicated, which shows a total of

16,852. Bringing in the people who are served under Medicare-Medicaid program, 12,7547, we come to a total 29,609 total handicapped users.

And then the next thing on the very right-hand side of the Table 3, [A-172] cumulative users affected, again as you go to day 20, we have 844 plus 309 from day 19 plus 328 day 18 and so on. So give total—count of total users affected day 14, and apply the similar, at the bottom, similar to the formula used in Table 1 [A-170] to arrive at the percentage served of users.

Q. Mr. Shaw, if in fact during the fiscal year, 1979 and 1980, that the Tennessee Medicaid program had placed a fourteen-day limitation on in-patient hospital stay, based upon the data and chart, Table No. 3, [A-172] what percentage of the handicapped Medicaid recipients would have had all their in-patient hospital needs covered?

A. 84.4 percent.

MR. SCANLON: Your Honor, before I go on to another table, do you wish some questions?

THE COURT: No, no problem.

Q. (Mr. Scanlon) Turning over, Mr. Shaw, turning to Table No. 4, [A-173] which is on Defendant's Exhibit 4-D, D-4-D Mr. Shaw, if you will, go ahead and explain this table, somewhat different from the previous tables, and if you will, describe it, please.

A. Table 4 [A-176] takes the patient days in Table 1, [A-170] looked at the users, number of people served, and in Table 4 [A-173] we're looking at the patient days being served. So what we've done on the left-hand column, again, number of days utilized zero to twenty. We've converted that, some multiplication in there, to give you the total patient days by users who used one day and users who used two and so on. For example, we—all the users who used two day level had a grand total of

17,976 patient days. We apply that methodology to each of the day levels and then the grand total down to the bottom, to 348,512 patient days.

And then the next column, users affected, again applies the same methodology from the front page, pulls the users affected from there and lists them out. Then what has happened in the final right-hand column where it says patient days cut back, there is an analysis of the days that would be cut back based on the fourteen day limit. So we took—we have 4,373 users who used it at the 20 day level. If they now use at the 14 day level, that's six times—they lost six days, six times 4273 gives you 25,638 patient days. Or users at 19 days, 495, they lose 5 days, so 5 times 495, 4 times 534, and so forth. So the right-hand column is saying the total cut-back days now would be 34,123.

THE COURT: Less than ten percent.

WITNESS: A little less than ten percent, that is correct, applying the formula at the bottom comes to 9.79 percent.

Q. Mr. Shaw, with respect to this table, the previous tables had Medicaid-Medicare recipient figures involved, these would not show up on this table, would they?

A. That is correct. That is not here, users by Medicare-Medicaid people is not here.

Q. That is by virtue of the fact outside the payment of deductible you did not process claims for Medicare.

A. That is correct.

Q. Mr. Shaw, just one final table. I call your attention to Table No. 6, Defendant's Exhibit D-4-F [A-175]. Again, if you would, go ahead and walk through this table and explain to the Court it's significance.

A. Table 6 [A-175] is patient days impact analysis paralleling what we did for Table 4, [A-173] except just working with the

subgroup who are identified as handicapped. So we have accumulated in the second column from the left, we have accumulated total patient days for total of 162,703, and brought out users affected from Table 3, [A-172] and then multiplied by the number of days cut back. So 2044 times 6309 times 5 and so forth to go on to the right-hand side of 6 shows total days cut back for the handicapped individuals and that totals 22,154 patient days. Comparing that 22,000 to 160,000 shows about 13.61 percent of the handicapped patient days being cut back.

Q. Again, Mr. Shaw, that's 13 percent total of all patient days for the handicapped.

A. That is correct.

THE COURT: The impact on the handicapped is 3.82 percent more than the total.

WITNESS: Yes, that is correct. This compares handicapped cut-back to total handicapped utilizers compared to all cut-back to total utilization.

THE COURT: Yes, I understand that. The 3.82 percent is the impact on handicapped as compared to total loss of days for the entire program. Is that not right?

WITNESS: I didn't do the subtraction myself.

THE COURT: 9.79 from 13.61, I think that's 3.8.

MR. SCANLON: Your Honor, I believe there are some other backup tables and charts in the study done by Mr. Shaw. Unless the Court has any questions on those, I have nothing further of this witness.

THE COURT: All right.

Cross-Examination

By Miss Clasbey:

Q. Mr. Shaw, I have some questions about defense Exhibit 4-A, Table 1 [A-170]. That is an analysis of all users. Does that include handicapped users?

A. That does include handicapped users.

Q. What would you need to do to analyze usage for non-handicapped users as opposed to total users, where would you make changes?

A. Well, your non-handicapped users would be what is left after what you had in Table 3. [A-172]

Q. You would take Table 3 and subtract those numbers from the numbers in the same places on Table 1 [A-170]?

A. What you applied in Table 3 [A-172], your population is either handicapped or non-handicapped, and what you had in Table 3 [A-172] is a compliment of the non-handicapped.

Q. So in order to determine the impact, say if you wanted to determine percent of users served when you're talking about non-handicapped population—

THE COURT: Subtract 29,609 from 98,121 and apply the formula.

Q. (Miss Clasbey) Is that correct, Mr. Shaw?

A. Depends on whether you're going to keep the Medicare-Medicaid, that is correct, you've got Medicare-Medicaid in both of those.

THE COURT: Both of those?

WITNESS: That's right.

Q. (Miss Clasbey) If you wanted to make these calculations—

THE COURT: Let's do that right now. Let you do that. Pull the handicapped out and use your pencil and tell me what the percentage is.

(Pause)

Q. (Miss Clasbey) I'll ask you to also subtract Medicare.

THE COURT: You don't mind if I do mine first?

(Pause)

THE COURT: Leaves 68,512, is that right?

WITNESS: Right.

THE COURT: Going to divide now, you give me percentage now. Where are you going to get your divider?

MR. SCANLON: If Your Honor please, I have a calculator Mr. Shaw might use if permissible.

THE COURT: I don't know if we have the data. Looks like we've lost one.

WITNESS: On Table 3 [A-172] you have your cumulative users affected, some 4617. Cumulative handicapped. That's really cumulative handicapped. That's really cumulative handicapped users affected. So the other ones are non-handicapped users affected. We've got Table 1 [A-170], you've got 7279. 7279, those are your total users affected.

THE COURT: Less 4,617.

WITNESS: Right.

THE COURT: 2662. As compared to—

WITNESS: 68,512. You have to take 68,512 minus 2662 over 68,512.

(Figuring)

Your answer would be about 3.9 percent cut-back, something like that.

Q. (Miss Clasbey) I didn't follow the calculation. What was it you came out with?

A. Okay. This calculation removed the handicapped people from the analysis, if I understand your question correctly?

Q. Right.

A. So step one, to remove them was you took from Table 1, [A-170] 98,121 people, which is your total population. You subtracted out from Table 3 [A-172] your total handicapped population, 29,609. That left you with 68,512 non-handicapped people. Then to get to the non-handicapped users affected by the cut-back, you took grand total from Table 1, [A-170] grand total users affected, 7279, minus your handicapped users affected, 4617, from Table 3, [A-172] to give you 2662 non-handicapped users affected. And then you convert that to a percentage, depending on whichever way you want to look at it, if you want to look at it as I have in these tables, percent of users served, it comes out to 96.1 percent of non-handicapped users served. If you look at the converse percent of users cut-back affected by the change, then it's about 3.9 percent.

Q. Which day are you talking about?

A. At day 14.

THE COURT: 3.9 percent, three point nine point something, the other way, impact analysis on handicapped users was three point eight, two.

Q. (Miss Clasbey) As I understand what you've testified to earlier, Medicare does not pay in-patient hospital days per se for Medicaid. Medicaid does not pay in-patient hospital days for Medicare recipients; is that correct?

A. No, Medicaid reimburses the in-patient deductible, $180.00 payment that the Medicare patient must incur upon admission.

Q. That's Medicare deductible?

A. That is correct.

Q. So then a cut-back in the number of in-patient days Medicaid pays for, does that have any impact on Medicare recipients?

A. No, these people Medicare-Medicaid patients will still receive full benefits, full coverage.

Q. How long does the Medicare patient get coverage in the hospital?

A. Medicare a little bit more complicated, it's by spell of illness. They receive sixty days and then some new rules come into play, between sixty and ninety, before ninety to a hundred and twenty, some other rules.

Q. So if you want to—wanted to analyze the impact these cuts are going to have on people who are going to be affected by these cuts, you would subtract Medicare out of that analysis, wouldn't you?

A. I don't know, because another way of looking at it is to remove them from that, but at the same time these people are still receiving their full coverage by the programs combined.

Q. But as to people who stand to lose on benefits by the cut-back from 20-14, Medicare people in that population?

A. That's why they're here, even with the program cut-back to 14 days, still not going to lose benefits, still keep their benefits.

THE COURT: Benefits, $180.00, that's not days. She says they are in there erroneously. And I see that she might have a point.

Q. (Miss Clasbey) In order to figure your calculations excluding the Medicare population, simply use the same formula but use the total before you add in the Medicare-Medicaid recipients.

A. You could apply the same formula below your total users on Table 1, [A-170] would be 51,070.

THE COURT: Figure that one out for us.

WITNESS: Okay.

THE COURT: On the 14 day.

WITNESS: Okay.

(Figuring.)

That shows 85 percent, so where you have 92.56 percent being served, this shows 85.7 percent being served when you pull those people out.

Q. (Miss Clasbey) Is it possible to make this analysis as in Table 1 [A-170] by excluding the Medicare population, Medicare-Medicaid, and for the non-handicapped only population?

A. Yes.

THE COURT: Go ahead and do it.

WITNESS: (Figuring.)

MR. SCANLON: Your Honor, I'm not sure what the witness was asked. I have trouble hearing.

MISS CLASBEY: I was asking if it were possible to do the same analysis for population of non-handicapped users after having subtracted out Medicare-Medicaid recipients.

WITNESS: Okay. Applying this same methodology that we did for non-handicapped with Medicare, and when you back—your non-Medicare, and when you back—your non-

Medicare back to analyze your non-handicapped, you have 2662 non-handicapped against, as we did previously, the same we did previously in analyzing just Medicaid only population, take 51,070 minus 16,852 who are your handicapped users, give you 34,218 non-handicapped users. Applying that calculationo the—come to percentage, and it gives 92.2 percent. So you're serving 92.2 percent of the needs of the non-handicapped users.

Q. (Miss Clasbey) At what—

A. At 14 days.

THE COURT: That's the same thing as with handicapped, that's 14 days.

WITNESS: Want me to repeat it?

THE COURT: I just told you. Figure the same thing at handicapped basis.

WITNESS: Okay.

Q. (Miss Clasbey) Handicapped, all you need to do is take handicapped out of Table 3. [A-172]

A. Right, take 16,852 from Table 3, those are your handicapped users.

THE COURT: All right, Table 6, [A-175] give me the percentage of cut-back days, cut-back with handicapped, you can't do it on days, can you?

WITNESS: No.

THE COURT: Give me what is the percentage of handicapped served on that basis? Will be served, you've already got that, 84 percent.

WITNESS: Right.

THE COURT: That's keeping Medicare in it. Take Medicare out.

WITNESS: Okay.

MISS CLASBEY: I'm sorry, Your Honor?

THE COURT: Table 3, [A-172] taking Medicare out.

(Figuring)

THE COURT: 76 percent?

WITNESS: That's right.

Q. (Miss Clasbey) Mr. Shaw, that's not the figure we've come up with.

WITNESS: I may have made a mistake up here on the spur of the moment, doing this.

Q. Would 72.6 be possible?

THE COURT: Well, let's see.

(Figuring)

WITNESS: I carried that to total users population to 51,070.

Q. Where do you get that number?

A. We said as we're comparing the percentage, want to get the percentage of non-handicapped users served, right?

Q. I believe we already did that one. I may have misunderstood what you were doing. I thought you were computing handicapped users served, Table 3. [A-172]

A. We took 16,852 minus 4617 and that gives 12,235 non-handicapped users served. What do you want to compare it to? I compared it to total population of users.

Q. (Miss Clasbey) My question was, using the formula that you have at the end of Table 3 [A-172] with the exclusion of the Medicare-Medicaid population, what would the result be?

A. Okay. So that is with total, in this case, total? 72.6. Now, that's 72.6 percent of handicapped users affected.

Q. At 14 days? So by excluding the Medicare population for handicapped users, 72.6 percent are served.

A. That's right. I just made an error. 72.6 percent being served, when you pull the Medicare people out.

Q. Right. For non-handicapped people, when you pull the Medicare out is—

THE COURT: 92.2.

WITNESS: Right.

Q. (Miss Clasbey) I just want to ask you a couple of short questions on Exhibit 5. You report in-patient stays by hospital and diagnosis, Exhibit D-5.

A. Exhibit D-5?

Q. Starts D-5.

THE COURT: D-5, A or B or what?

MISS CLASBEY: Attachment 1, Title, excessive in-patient days by stays by hospital. Is that per stay, would you explain that?

WITNESS: This chart—

THE COURT: What are you explaining in the first place?

WITNESS: As I understand, I'm explaining D-5-A which is entitled, "Attachment 1, Excessive In-Patient Stays by Hospital."

THE COURT: All right.

WITNESS: Okay. This report is based on six months of actual Tennessee Medicaid experience. The uses within the analysis, length of stay by diagnosis to look at each hospital in the state, and see how many days, how many patient days were provided by that facility in excess of 95 percentile length of stay criteria that's given in Column, Days in Excess of PAS.

THE COURT: What is PAS?

WITNESS: PAS, Professional Application Study, I believe the middle word is application, it's a compilation of nationwide and regional statistics. This is telling the amount of patient days that were covered, reimbursed by the programs in excess of the 95 percentile PAS.

THE COURT: That's per stay, PAS is an average of one stay in the hospital?

WITNESS: It's per stay, per condition, but what is here is summary, so—

THE COURT: Okay.

MISS CLASBEY: No further questions.

THE COURT: Step down.

(There being no further questions, the witness was excused.)

THE COURT: Call your next witness.

MR. SCANLON: Call Mr. W. K. Vaughn.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF DR. W. K. VAUGHN

[Transcript of Proceedings, pp. 103-109]

Direct Examination

By Mr. Scanlon:

Q. Dr. Vaughn, if you would, please tell us where you are from and where you are employed, and your profession.

A. I am a bio-statistician, employed by Vanderbilt University School of Medicine in Nashville. I am an associate professor there with tenure, and I am the Director of the Division of Bio-Statistics in the medical school.

Q. Doctor, very briefly, if you would, tell us what does a bio-statistician do, what are the types of things you delve into?

A. Well, as an applied statistician, I delve into many different areas. Some examples, I teach medical students, teach graduate students the fundamental theories of statistics. I'm involved

with many investigators in the medical school in terms of analyzing their data using statistically sound principles. I am also principal investigator with several different contracts, one that's running right now has to do with determinants of outcome of kidney transplantation.

MR. BARRETT: Your Honor, we've offered to stipulate all the qualifications of Dr. Vaughn with Mr. Scanlon.

THE COURT: It's stipulated.

MR. SCANLON: Your Honor, what I was trying to do here was to elicit a little bit about the type of things Dr. Vaughn does.

Q. (Mr. Scanlon) Dr. Vaughn, over the last few weeks did I request that you perform an analysis of certain data with regard to the Tennessee Medicaid program.

A. Yes, you did.

Q. Doctor, I called you and did you in fact produce a report?

A. Yes, I did.

Q. What were you asked to do when you did the report?

A. I was asked to look at the data, data you presented, and to determine if there were disparate or disproportionate utilization in terms of handicapped versus non-handicapped Medicaid recipients.

Q. With respect to what aspect of the Medicaid program? You weren't asked to look at all—

A. No, just the data that you presented to me.

Q. With respect to in-patient hospital—

A. I'm sorry, with respect to in-patient hospital utilization, that is correct.

Q. Doctor, I call your attention to Defendant's Exhibit D-6 [A-179] in Collective Exhibit D-6 through D-C, D-6-B and C, [A-179-184] and does this constitute the analysis you did?

A. Yes, it does.

Q. Doctor, I wish at this time, if you would, to go through and tell us what you did, the data you arrived at, I think it might be best if you'd go ahead and explain it in terms—it's a little bit complicated, and I'll stop you at points along the line.

A. Well, the data you see which is labeled Table 1-D—6-C, [A-182] categorized in terms of non-handicapped and handicapped Medicaid recipients. The second column and the fifth column which are headed, Number of Recipients Receiving Service, are the number of recipients that have been previously alluded to by Mr. Shaw. When I was asked to analyze the data, I thought the best way to look at the data would be to look at it in terms of Medicaid eligibles, not in terms of number of recipients receiving service. My rationale for that was if you have more eligibles in one category than the other, you look at the total numbers of handicapped and non-handicapped who utilize the service in the category that had more eligibles, you would be expecting a higher usage rate. But that wouldn't necessarily reflect—would not necessarily give an accurate reflection of the actual utilization rates among the two eligible populations. So what I did was to compute something called person years of eligibility. The reason I did that was because in the category of non-handicapped and handicapped Medicaid eligibles, people are not entirely eligible during the year. Sometimes come on for a month and go off for a month. So I utilized the idea of person years of eligibility. What this means, you look at each month during the fiscal year, you compute the number of eligibles for non-handicapped and handicapped for that month, and you add all those twelve months up and you divide by twelve and that's the number of person years of eligibility for that period, and in this case, this analysis for 7/1/69 through 6/30/80.

Q. What you are telling us is that at any one given month there will be a certain number of eligible Medicaid recipients at any one period of time, but if you add it up, total number of eligibles in every month, it would be much more than that because some people are on the program and go off.

A. That's exactly right.

Q. I believe the figures that you looked at of all the separate individuals who at one time or another were eligible for Medicaid during the year was in excess of 400,000.

A. In both categories.

Q. In both categories? Whereas at any given month, any given time, normally only 300,000 people are eligible.

A. That is correct.

Q. So what you tried to do was compensate for this phenomenon in order to come up with the utilization rates between handicapped and non-handicapped.

A. Right. Makes them more comparable in terms of eligibility status. So utilization rates then are calculated by taking two columns headed number of recipients receiving service in both categories, non-handicapped and handicapped, and dividing the number of recipients receiving service by the number of person years and coming up with utilization rate, which is given in columns 3 and 6.

For example, if you look at the number of days of in-patient service, day number 1, you see 3,467 recipients receiving service, and their utilization rate 13.4 persons hospitalized per 1,000 person years of eligibility.

You can compare that to —you can see what happens to the 932 on day 1 for the handicapped and their utilization rate is 12.1.

Q. Doctor, with respect to the utilization rates throughout the spectrum of going from one up to twenty days, how would you characterize utilization by the handicapped versus non-handicapped?

A. Well, I think that's fairly obvious from the table, if you look at days 1, 2—sorry, days 2, 3,—well, in most of the cases handicapped utilize at a higher rate, and for the life of me I can't figure out there day 2, I guess handicapped utilized at a lower rate, and that appears to be the only day that occurred. So in general, handicapped utilized at a higher rate.

Q. And this utilization, higher utilization holds true with the exceptions you cited throughout the whole period, is that correct, going from one to twenty days?

A. Yes, that is true.

Q. Doctor, as bio-statistician in your professional expertise did this surprise you, this higher utilization by handicapped?

A. Well, not really, because you know handicapped are generally sicker, and they are probably older population, so the differential didn't surprise me all that much.

MR. SCANLON: Your Honor, I have no further questions. I think the study speaks for itself.

MISS CLASBEY: No cross-examination.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF
TENNESSEE, NASHVILLE DIVISION

Civil Action No. 80-2043-NA-CV

In the Matter of

Rosier Jennings by his next
friend, Kathleen Jennings,
et al,
Plaintiffs,

vs.

Lamar Alexander,
Defendant.

The deposition of DR. JAMES E. WORD

[Transcript of Deposition, pp. 6, 14-16]

Direct Examination By Mr. Bonnyman

A. ... Now, on the hospital reduction, relative to changes in methods of reimbursement which pertains to the penalty on vacant beds, we have been notified by Region Four that we would, in fact, have to have prior approval on that, because that is change in the method of reimbursing for in-patient hospitalization. And that is—that would require prior federal approval.

Q. They have not, when you referred to Region Four you are talking about the Atlanta office of the Health Care Financing Administration?

A. That's right.

Q. They have not disallowed that they have only told you you must get approval before you implement it; is that right?

A. They wrote us and told us we would have to have prior approval. And to this date they have not indicated, to my

knowledge, either acceptance or rejection of that.

* * *

Q. I think you covered this at the preliminary injunction hearing, but am I correct that the basic goal of the reduction in covered day was the cost savings? Let me explain that question a little bit more.

As I understand the department's position, in the area of, for example, certain drugs that are being deleted from the formulary, there is an interest in saving money, but there is also a judgment being made that those drugs are not medically efficacious or contraindicated for which Medicaid is now purchasing the drugs.

In contrast, I am just asking to clarify whether there is any purpose in reducing the in-patient hospital days, apart from that of cost savings.

A. To my knowledge there was not.

Q. Does the department have any written self-evaluations of its compliance with its assurance of non-discrimination against the handicapped; to your knowledge?

A. Do we have any written—

Q. Self-evaluations.

MR. SCANLON: In what area of accomplishment by the Tennessee Department of Public Health: affirmative action, local health?

MR. BONNYMAN: I am sorry, nondiscrimination in the administration of the Medicaid program against the handicapped under Section 504.

MR. SCANLON: And this would be something in addition to what you have been provided in the production of documents?

MR. BONNYMAN: Right.

A. I honestly don't know. I mean I know that we have had specific inquiries which we have dealt with that have come from Office of Civil Rights. I know that Carol Mitchell, who is dealing with that, has worked specifically as relates to nursing homes and being—insuring that in the survey process it is completed.

But I know of two meetings, three meetings in the last two years I have had with O.C.R. people about these issues. But as far as a self-evaluation, I am not familiar with any, if there is any.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF SAMUEL MARNEY, M.D.

[Transcript of Deposition, pp. 17-32]

Direct Examination

By Mr. Ray:

Q. Let's talk for just a moment about the reduction in the inpatient hospital services. The State has proposed to reduce impatient hospital services per year from twenty to fourteen. Are you aware of that?

A. Yes.

Q. What effect, if any, wuld the limitation of fourteen days per year maximum have on your practice, in treating many of these disorders? And could you name some of the disorders and give examples, if you have them?

A. The patients that I admit to the hospital are primarily those with obstructive lung diseases which includes asthma, chronic bronchitis, and emphysema. A number of these patients simply require longer hospitalization for intensive therapy than fourteen days.

In fact, some of them require longer than twenty days. And the effect of sending a patient out before the treatment is completed is simply that he or she will be back in the same condition or worse in a very short time.

It is my practice to treat a patient in the hospital with one of these conditions, until the problem is solved for the moment. And this may vary from three or four days for the patient who has an acute but limited problem, to a patient that I recently kept in Vanderbilt Hospital, who was not a Medicaid patient, for fifty days.

And it seems to me that it would be appropriate, medically, to be able to treat a patient until the condition warrants discharge.

Q. Are you familiar with the concept of stay of illness in the inpatient hospital area?

A. Yes.

Q. Is it your understanding that stay of illness would be where there is a durational limitation on what Medicaid will reimburse for, for a particular stay, but there would be no limit applied on the number of times that the person could be admitted to the hospital?

A. Yes.

Q. From a medical point of view, how would the change from an absolute durational limit to a stay of illness standard effect your practice, treating the conditions which you treat?

A. It would help considerably, because with the absolute limitation on the number of days that Medicaid patients can be hospitalized, we often wind up treating patients in a suboptimum fashion as out-patients. Some patients are simply going to have to be admitted several times a year as emergencies, whether we like to admit that legally or not.

And I suppose there are mechanisms available whereby we can declare a patient an emergency and accomplish this. But it seems to me that Medicaid should recognize the fact that whereas some patients with asthma and obstructive lung disease may go for years without being admitted, a small number of them are going to have to be admitted repeatedly, several times a year, for an aggregate of much more than twenty days.

And it would considerably simplify the technical practice of medicine if that were available.

Q. Have you had any experience regarding trying to get someone whom is not in an emergency or an emergency situation, but trying to get that person with one of these disorders into a hospital, after they have either expended their Medicaid days or do not have coverage otherwise?

A. Well, almost everybody has been in admitting over at Vanderbilt Hospital, and I assume this would be true of other hospitals, has had to go to local county judges to ask for authorization of funds to admit a patient who absolutely required treatment. And if the patient has run out of Medicaid days, then that sometimes has to be done.

Q. Have you experienced difficulty, yourself?

A. Yes.

Q. Could you describe some of the difficulties that you have experienced?

A. Well, if a patient simply cannot breathe and has to be admitted to the hospital, then we have to find a way to do it. And that has happened repeatedly.

Q. Have you had, yourself, difficulty in getting patients admitted to the hospital, after either their Medicaid days has—have expired, or did not have third party coverage otherwise?

A. Yes.

Q. Could you describe some of those?

A. I recently had a patient in the hospital who simply dragged along at home until he was declared eligible for Medicaid, and once we got him covered, he was able to go out of the hospital and be a candidate for vocational rehabilitation.

But he had wheezing, coughing, shortness of breath, every day, so he was unable to do any work, whether he wanted to or not. He simply was not able to. And once we treted him for about eight days in the hospital, his chest cleared. He felt dramatically better. And that was directly the result of Medicaid, once it was available.

Q. Let me just ask a question in that area, that may enable us to just sum up your testimony and your opinion in this area. Would you state whether you have an opinion regarding any difference that it might make in a person having available Medicaid days, if the State went to a stay of illness standard, as versus having exhausted their Medicaid days under an absolute durational limit?

Do you have an opinion regarding that patient's ability to get back in the hospital, if the State were on a stay of day instead?

A. If I understand your question correctly—

Q. I am sorry.

A. —it would be very difficult for us to get a patient back into the hospital, after the twenty-day limit has been expended at the moment. If we did have a different policy that allowed the patient to be admitted for each episode of illness, it would save considerable effort on the part of the patient and the physicians, and it would inevitably lead to a higher standard of care.

We also would admit patients before they become critically ill, and have to be declared emergencies. And this almost inevitably would decrease the number of days that they have to be kept in the hospital.

Q. Dr. Marney, I don't know how you made such a clear answer to such a convoluted question. Thank you very much. Let me ask you one final question, and then Mr. Scanlon would like to ask you some questions.

During your testimony regarding the inpatient hospital services, you use some terms like it would be more simple. It would be a lot more efficient if we had a stay of illness. I want to make sure that your testimony regarding your opinion of it being better to go to an episode standard for the Medicaid program is based upon medical necessity and not on just any sort of administrative convenience. Could you comment on that?

A. I hope I conveyed the fact that some patients simply are going to have to be in the hospital more than the specific number of days that are currently allowed. And it would make sinse to me to have to admit this and from the outset, and have a set up that would allow us to admit patients when it is medically indicated, rather than when they are having a life-threatening emergency.

MR. RAY: That is all I have.

Cross Examination

By Mr. Scanlon:

Q. Doctor, I would like to first of all inquire with regard to the testimony on the antihistamines. And perhaps clarify some of the terminology we are using here. When you indicate that these drugs will not be available to your patients, is what you are saying is that Medicaid would not pay for them; is that correct?

I mean, we are not stating that these drugs aren't available to be purchased somewhere.

A. No, they are available in drug stores.

Q. That's right. And so when we talk about the drug not being available, what you are saying is that they through my clinic,

there is a large number of Medicaid patients who would be deprived of this supply of medicine at least from Medicaid.

Q. Doctor, with respect to your testimony on the hospitalization of your patients, you have indicated that you would find a stay of illness therapy or concept much more preferable than an ultimate cap or ceiling. I would like to explore just a little bit here — and I am not sure whether Mr. Ray qualified the business of the stay of illness.

Are you saying then there should be no limitation or ceiling on the number of days that should be provided by the Medicaid Program for a particular patient?

A. Medically, that would be the best plan.

Q. Right. In a concept of a stay of illness, did you perceive what Mr. Ray was asking you, was within that stay of illness, there would be a particular limit?

A. There is a surveillance committee at Vanderbilt, which looks at the length of stay, and requires faculty to justify holding a patient longer than the standard of care outlines for any given condition.

But if there are complications — and sometimes there are — then we simply keep the patient until the illness so justifies letting the patient go.

Q. What I am saying is that there have been developed, statistical data and given formularies, and I use that very broad term, formulary, which indicated length of stay for normal illnesses commonly referred to as the P.A.S., as I have heard it referred to.

A. Yes.

Q. Now, what I am asking, would you still favor a stay of illness concept as outlined by Mr. Ray, if, in fact, that there was imposed by the Medicaid Program, a cap by stay of illness — let

me give you an example. If, in fact, the Medicaid program would say for a female between the age of twenty and thirty-four, that if she were to go into the hospital under an uncomplicated, nonsurgery, maternity delivery of a baby, that the Medicaid program would pay for three days? This is what I am talking about.

And my understanding of a stay of illness, it wouldn't be just whatever is medically necessary, but there would be certain limitations that would be imposed across the board to all patients. Now, would you still find that preferable to an outside limit?

A. Yes, I would.

Q. Why, Doctor?

Q. Because some patients simply have to be admitted more often than a total of twenty days a year will permit. Assuming that one hospital stay might be four days and another might be fourteen days. The patient may, in fact, need three, or even four hospitalizations during the year.

Q. All right. Even with the limitations, would it also be — I would assume that you would want the limitation that would be placed upon the first spell of illness, by diagnosis category, or whatever, would have to be reasonably related to the illness; is that correct?

A. Absolutely.

Q. You would not want it to be an arbitrary type of thing where we would say we are going to pay, okay, one day here and two days there?

A. Yes. I don't mean to imply that I don't think there should be standards of care. That is what we call it. There should be. And there are carefully worked out average lengths of stay for various types of illness, which you referred to. I am in favor of that.

But the average length of stay for asthma or severe bronchitis may be ten days. And the patient may need to be in the hospital more than twice. And there are also, needs to be some room for some exceptions because a few of those people are going to have to stay longer than ten or twenty or thirty days.

Q. Perhaps even forty or fifty days.?

A. And so my point is simply that I am not making the law, but from a medical standpoint, there does need to be provisions for the few patients who need much longer than the average stay.

Q. Doctor, you indicated that there was a comment you made, and I want to perhaps clarify for me, you have this problem when people are in the hospital and they are running out of their Medicaid days — is that a problem — and I believe some language you used about the problem of sending them out. Could you describe that problem for me; what is this?

A. If a patient is admitted to the hospital for severe asthma, which means wheezing, chest tightness, shortness of breath, that is caused largely by bronchitis, by which I mean secretions so thick that they obstruct the airways, then the patient is going to continue to be short of breath until the secretions have been fully cleared.

Now, in some cases that can be accomplished in one week. In other cases that takes three weeks or longer. And my point is simply if we send this particular patient out before the secretions have cleared, and take the patient off the bombastic treatment that we use in the hospital, which the patient cannot duplicate at home, then the condition is quickly going to revert to the same or worse than when he came in.

And that is my point. That we need to treat some patients of this sort until they really have cleared, or we are going to take one step forward and two backward.

Q. The point I was trying to clarify is that in some people in the Medicaid program, or involved in talk about it, is the nineteen-day syndrome, where someone is approaching in the hospital — they are approaching the outside limits of their Medicaid. And I am sure this is true with people who have certain hospitalization insurance. Is it the patient's choice to leave the facility at the end of their coverage, for fear they can't pay the bill, or does the hospital say you have to go home at this point?

What is it that causes the person to go out of the hospital at that time? Does the hospital, in a sense, throw them out the door when their hospitalization goes off, or does the patient decide to leave, because they can't pay the bill?

A. Fortunately, a hospital may not throw a patient out, unless the physician says it is all right. Some of the patients do elect to go, because of the overwhelming bill that may ensue. But it is the physician's choice, in the majority of cases.

Q. I see. So this does —

A. I beg your pardon. In the cases I know of.

Q. I understand that is all you can testify to.

A. I don't know about the majority of cases.

Q. But what you are stating, though, is that at any point in time that an individual approaches limits of their insurance coverage or their Medicaid coverage, that this does create a problem for you in treating that patient? And as well as a problem for a patient, of course?

A. That is true.

Q. So that would be the case whether or not the limitation was twenty days, thirty days, whenever that individual gets that limit, there is a particular problem?

A. That is true.

Q. All right. And if we had a system set up of on a per spell of illness basis, and we applied a particular standard of X number of days, let's say referring back to the maternity patient, we applied to her a standard of three days. That if the doctor felt she ought to stay a little bit longer than the three days, and all that her insurance or Medicaid would cover would be the three days, she would have this same particular problem; is that correct?

A. She would have the problem of length of stay.

Q. Right.

A. And she couldn't get pregnant often enough to use up her twenty days one year.

MR. RAY: Excuse me, Frank, let him finish.

A. But for the greater problem, as I see it, for the people I treat, is that they may need multiple admissions in one year. And that we really don't have room for under the maximum number of days per year as we would per hospital stay.

Q. But even with the individual who would have the multiple admissions that would have to come in, and we could take from what you are expressing to me, and some testimony we heard yesterday, that people who suffer with asthmatic conditions do tend to come in for quite lengthy periods of time?

A. Some do. Some never are hospitalized.

Q. That even with these individuals that would come in and stay four or five times a year, they would face a problem when they would hit that limit for that particular stay?

A. That is true.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF GEORGE MONTOURIS, M.D.

[Transcript of Deposition, pp. 17-20]

Direct Examination

By Mr. Ray:

* * *

Q. Okay. I want to ask some questions about your treatment of patients who require inpatient hospitalization. Do any of your patients require inpatient services?

A. Yes, sir, they do.

Q. Do you have any patients who have disorders who — which would require multiple admissions to hospitals?

A. The seizure patients could require multiple hospitalizations. Any of my stroke patients could because of complications that occur following strokes. The M.S. patients often require multiple hospitalizations.

Individuals who come for diabetes, diabetic neuropathy, occasionally they would be the less apt to have to be in the hospital several times because of a neurological disorder. Degenerative diseases of neurology often require hospitalizations. Degenerative brain diseases that we see, could easily because of the complications involved.

Another one that is hopefully not several hospitalizations but a prolonged hospitalization at the onset is Gillian Barre Syndrome G-il-l-i-a-n B-a-r-r-e Syndrome, that I recently had a child who is actually applying for Medicaid assistance who was hospitalized at Vanderbilt for a total of thirty days.

Q. Some of these diseases which require the multiple admissions, let's just take your stoke victim, for example. Typically, or specifically, if you remember a specific patient, what would be the first year's history, as far as hospital admission of a stoke, typical stroke victim? I am talking about as far as duration of stay times.

A. That would depend on the age. And that would depend on some of the possible causes of the stroke. If you are dealing with a relatively young person, and they have had a stroke, you would have to count, I would say, a minimum of two—I am thinking in terms of the tests that would have to be ordered. How aggresive you would get in the treatment, investigation, and ultimately possible surgery for it. So I would say you would have to count from the neurologist's point of view, barring the neurosurgeon who would then immediately follow if surgery was indicated, probably ten to fourteen days, minimum.

Q. Is that the first?

A. That is the first time. If you are dealing with an elderly patient, or not even extremely old, but say in your mid ages of fifties to sixties who may or may not have other complications, it is conceiveable in the non-operatable cases, that they would, if they continue to have strokes, that you would require at least two or three hospitalizations.

I am trying to recall some of the cases. Since I have an E.E.G. lab that travels throughout the counties, in the six months in operation, I can think of at least two or three cases that have had multiple hospitalizations with either an incephlopathic state or stroke, that has required that they be rehospitalized.

Q. Generally, how many days duration for each episode?

A. Well, you have to consider that the patients come in an unstable condition because that is the only reason you would hospitalize someone is that their situation is precarious.

I would say at least ten to fourteen days each time, because you need to have the individual stabilized. The aim is obviously to give optimal medical care. And they need to be stabilized before disposition can be taken elsewhere.

Q. I have one final question. How much are we paying you for your testimony and all of the time we spent together?

A. Nothing.

Q. Why are you doing it?

A. Because I believe in giving good medical care to people, irrespective of their financial income.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

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Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF RICHARD STEIN, M.D.

[Transcript of Deposition, pp. 15-22]

Direct Examination By Mr. Ray

Q. Okay. Now, you have indicated before in your testimony, that you treat leukemia patients. And I believe you said some cases of acute leukemia patients?

A. That's correct.

Q. Does an acute leukemia patient require hospitalization?

A. Yes. THere has been a lot of progress in the management of patients with acute leukemia. Approximately ten years ago, acute leukemia was invariably fatal, and 90 percent of the patients were dead within two or three months.

Let me state that maybe fifteen or twenty years ago that was the case. I guess not all of the progress is in the last ten years.

At least at this time, however, eighty percent of the patients with acute leukemia have initially a favorable response, which we call a remission. And of this group of patients, many of

them live one or two years. And some of those patients are cured.

To treat these patients effectively, and to achieve these good results, we need to put patients in the hospital to administer drugs and more importantly, to give supportive care with antibiotics and transfusions of platelets, and occasionally, transfusions of white blood cells that these people cannot produce because they have leukemia.

The average hospitalization for someone with acute leukemia is three to four weeks. Some patients take as long as six to seven weeks during that first hospitalization.

These patients then need to come back in the hospital for what I would like to call, I think for simple purposes, touch-up treatments to keep them doing well.

And often they require to do that, three or four times during their first year of—the first year following diagnosis.

Q. That three or four times of in-patient hospital services?

A. That is the way we manage our patients routinely at Vanderbilt.

Q. And approximately—and I know we are generalizing here, but approximately how long for each of these subsequent admissions would be required?

A. For the drugs we usually use those subsequent hospitalizations last four to five days.

Q. Okay. Are there any other ailments which you treat, which also would require multi-admission to in-patient hospital services?

A. The one most obviously comes to mind, with respect to that question is sickle cell anemia. Our patients with sickle cell anemia are prone to have painful crises that can be precipitated by viral infections, or they sometimes are without any apparent

cause. These patients need to be admitted at the time of these painful episodes. They only have to be in the hospital only three to five days, but these episodes may occur once a year to five or six times a year.

So in our patient population with sickle cell anemia, we have a number of patients who will have four or five admissions to the hospital a year.

Q. Okay. Are you aware that the Department of Public Health has proposed to reduce in-patient hospital days on an annual basis from twenty to fourteen?

A. I am aware of that recommendation.

Q. Let's concentrate on the fourteen-day maximum per year limit. Would you state your opinion, if you have one, regarding your ability to treat those two diagnoses listed above, within that fourteen-day standard?

A. Well, with respect to patients with acute leukemia, you simply cannot effectively treat someone with acute leukemia with a fourteen-day stay in the hospital.

If you knew in advance that you could keep someone in a hospital for only fourteen days with acute leukemia, you would have to give them inadequate therapy, which would simply cut their chances of having a good response from eighty percent to probably twenty percent.

If you didn't know in advance and simply planned on treating the patient with what seemed to be the best therapy and sent them home at fourteen days, you would simply, by being unable to support the patients after fourteen days, kill all of the patients. You really can't do it.

Acute leukemia requires a month in the hospital at initial hospitalization, and there is really no way to manage a patient effectively with any fixed time. Of course, let me state, because what I said was a bit inaccurate, people with acute leukemia

need to be in the hospital until they go in remission. That takes on the average of three to four weeks.

But we have occasional patients who take six to eight weeks. The point is that the patient needs to be in the hospital, getting supportive care, until the bone marrow recovers. However long that takes it. And it is impossible to give any fixed time limit on what would be required there.

Q. Wouldn't that be the same problem if the standard were ad it is now, twenty days?

A. I have to state that both a fourteen-day standard and a twenty-day standard present equal problems, if one is going to deal with a disease like acute leukemia. That neither one of those time limits provides an adequate time frame to administer adequate therapy to that disease.

Q. Do you have an opinion, and if you do, would you state your opinion, regarding—and I am speaking strictly from a medical necessity point of view—the impact on your ability to provide medically necessary care to these individuals, if there is a set time limit per year, as versus a set time limit per spell of illness, or stay or illness? Do you have such an opinion?

A. Well, the ability to render the care would simply depend on the decision to be made by the admission on whether the patients would be admitted to the hospital or not. And whether or not Vanderbilt would choose to pick up when there is no available funding for the patients.

In essence, if a patient cannot be kept in the hospital longer than fourteen days, the patient cannot be treated.

Q. Let me state a hypothetical for you, and then ask you your opinion, if you do have one. Let's hypothesize a system of limitations on in-patient hospital services which would have no limit as far as an annual durational basis.

On an annual durational basis. But it would have a limit on the number of days that Medicaid would reimburse for per episode, or per stay. Let's just hypothesize that would be between ten and fifteen days per stay. As between a system which would impose an absolute maximum limit on in-patient hospital services, and a system that would impose a limit on a stay per illness in the in-patient hospital area, and reference in your opinion, if you give one, those two diagnoses which we had talked about earlier. The sickle cell anemia and the acute leukemia development. Your opinion, regarding which one of those standards would enable you to provide medically necessary care in a more efficient way.

A. Well, a system that gave a number of days per admission, with no limit on the total, would be better for the patients with sickle cell anemia, because you could bring them in when they needed to be in. You could render appropriate care for each episode and there would be no limit.

The patient with acute leukemia presents a difficult problem under either system. Quite frankly, because that first admission that is—unless the limit is such that the first admission in first leukemia may be four to six weeks, and other admissions of another length. That first admission of acute leukemia presents a problem.

The point is, a physician—and all I can state is as a physician—is what people need and what kind of care people need. And when patients have acute leukemia, they need initial admissions that are long and usually need follow-up admissions that are of variable lengths. Let's say five to seven days, several times during a year.

And how one comes close to meeting that need is administrative. So, I can't really comment beyond that.

Q. But the sickle cell anemia, you would comment that it would put you in a better position to provide medically necessary care for these persons?

A. Yes.

Q. Okay. I want you to assume some more facts.

A. Okay.

Q. Assume that a hospital would not force you, as a doctor, to discharge your patient who had acute leukemia, after the number of days had expired for Medicaid coverage. Assume that.

A. (Witness nods in the affirmative.)

Q. And assume the same stay of illness standard. What would be your opinion, if any, then, regarding the treatment of those?

A. Under the assumption that the hospital would not compel discharge of the patient, which I would say, in view of my experience at Vanderbilt is, of course, a reasonable assumption, then the best system is one that allows multi-admissions with a length allowable for each admission, with no maximum on total.

Q. Just want to make sure that I understand your testimony. When you are saying best, what do you mean by best?

A. Oh, I guess—I am sorry—well, what I am saying is that I guess we were comparing two systems. I should say it is better to have a system that you could bring patients in on numerous occasions, then to have a system with fixed limits, where you may have difficulty getting a patient admitted into the hospital.

Q. Then I take it you are speaking, of course, within your expertise? You are talking about medically better?

A. I mean better, with respect to being able to treat the patient as the patient needs to be treated.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF JOSEPH M. STINSON, M.D.

[Transcript of Deposition, pp. 17-22]

Direct Examination

By Mr. Ray:

* * *

Q. I want to ask you a few questions about the in-patient hospital service reduction, or proposed reduction. Are there any diseases in your specialty, which would require periodic episodical admission to hospitals over a period of a year?

A. Yes. I suppose the examples of asthma, which is episodic by definition.

Q. I know it is hard to state this, but if you had to generalize, regarding an asthma patient, how many times would that patient require in-patient hospital services per year?

A. How many?

Q. I am not talking about duration, at this point. I am just talking about times they would need to be admitted.

And if you have specific case histories from your practice, you, of course, could use them without naming the name.

A. Could I give a statement off the record?

Q. Yes.

(Whereupon, an off-the-record discussion was held.)

Q. (By Mr. Ray) The question was, has there been anything in your experience that would—

A. Well, part of the reason I said off the record is because my experience is getting to be pretty good. You know, the frequency of hospitalization is declining, because we see them in the out-patient setting, whenever they need to be seen.

Q. Okay.

A. If anybody starts getting short of breath. If they cough more, if their sputum turns color, we tell them to call us. We will see them if we are here, any day; appointment or no appointment.

And if it is in the middle of the night, we would rather for them to come to the emergency room, than to wait to the next morning to call us, regardless of the cost of the emergency room. It does not cost as much as a stay in the hospital.

Q. Well, even if it has improved, isn't it a fact, though?

A. I will say probably four or five times a year would be your typical asthma patient's need to be hospitalized.

Q. Is there any way to generalize about the duration?

A. With asthma, generally, control is not too difficult. I would say about ten to fourteen days.

Q. Each?

A. Each.

Q. Each stay of illness?

A. Some of them might be a little shorter and some of them might be a little longer. But we could usually get them improved pretty fast.

This is not the case, necessarily, with bronchitis. Chronic bronchitis.

Q. Is that another example?

A. This is another example. In some respects, it is similar to asthma, except it is more chronic. It is less episodic. It is more sort of continuous.

And these patients, when they have an exacerbation and come into the hospital, very often they have so little oxygen in their blood, it is almost incompatible with life. And they very often have to go through the intensive care unit. They have to have mechanical ventilation and intensive intravenous therapy and physical therapy, and the whole works.

Some of these patients can require thirty days before they really are able to leave the hospital.

Q. And it is likely that this stay would be thirty days each episode, or would it change?

A. There would be a range, probably from fifteen to thirty days.

Q. Per episode?

A. Right.

Q. And when we are saying that, we are talking about time required in-patient hospital to adequately treat these patients?

A. Yes.

Q. Are there any other types of ailments that will require these?

A. Broadly, any of the chronic diseases of the lung can require similar stays. Part of the reason is because regardless of the disease, the lungs tend to react the same way. So that one of the diseases we see quite commonly is called sarcoidosis. And when it becomes severe, the patient is very much like those with chronic bronchitis.

Q. What is that disease?

A. Sarcoidosis is a granulomatous disease. That doesn't mean anything special. It causes shadows on the chest x-ray. And if you cut some of them out and look at it, it looks very much like what you see in tuberculosis. But it is not infectious. We have no idea what causes it. It just happens.

Q. Does it effect the oxygen supply to the rest of the body?

A. Yes.

Q. How does it do that?

A. Well, you know, the lungs get oxygen for the whole body. So if the lungs can't get enough oxygen, then the whole body suffers. That is why most of these diseases are so serious.

Q. So, it effects the absorption of oxygen?

A. Right. We call it supply.

Q. Oxygen supply?

A. Right.

Q. Regarding these diseases that would require periodic in-patient services, can you give, from a medical point of view, your opinion regarding what would enable you to treat these diseases more effectively, whether a set standard or durational limit on in-patient hospital stays per year, or stay period on illness, per illness standard? Do you understand the question?

A. I think so. "X" number of days per year or "X" number of days per illness?

Q. Yes.

A. I think a stay per illness would be optimal.

Q. Why?

A. Well, we have talked about eposidic exacerbations requiring hospitalizations. And one illness, or one episode could use up all of a patient's days for that year, if it is on a day's per year basis.

And then the patient would have an acute exacerbation later on, he might not be able to get into the hospital and might die because of that.

MR. RAY: I believe that is all I have.

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IN THE UNTIED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend,
Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of
Tennessee, et al.,
Defendants.

DEPOSITION OF GORDON TURNER

[Transcript of Deposition, pp. 6-11 and 15-19]

Direct Examination

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By Ms. Clasbey:

Q. Through your admissions and referrals, are you familiar with the admission practices of a number of hospitals in the area?

A. Yes, I am. I have practiced here 25 years.

Q. Okay. Are a number of your patients poor or receiving Medicaid?

A. Yes, they are.

Q. Okay. What is your experience when trying to admit a patient who has no remaining Medicaid coverage to the hospital?

A. Well, it is usually a fairly good hassle getting a patient in, if it is not an emergency or life threatening situation. It is really a hassle, unless it is a life threatening situation or an acute emergency.

If it might immediately become a life threatening situation, we could get the patient in. Then soon after admission we usually have problems keeping patients in. We have to try to get the patient stabilized or in such a condition as they can be referred or transferred to another facility that might accept a full non-paying patient or full self-paying patient.

Q. What is your experience with patients who in your judgment need hospitalization but are not in the emergency or critical situation in getting them in?

A. It is usually a pretty good hassle.

Q. What do you mean by that?

A. I mean that if it is somebody who needs care that is not life threatening, if I send them to the hospital, I will get a call back and they will say Dr. Turner, this patient's Medicaid days are out, or they have used up their Medicaid days and they no longer have anything. Would it be possible for you to treat her later or refer her to some place that will take care of indigent people?

That's the usual answer I get.

Q. Have you ever had occasion where patients could not get into the hospital because their Medicaid days were out, when you felt they should be in?

A. Well, recently—I will give an example.

I had a patient without a life threatening situation who needed to be in the hospital for surgery. She got to the hospital and she did not have Medicaid days left and, therefore, could you wait to do this procedure later?

If there is such a thing as a minor surgery procedure, this was a minor surgery problem, but if it were great, it might make her a little more profitable to do the things, but I had to delay this.

She is not being treated because of the fact of the Medicaid days running out.

Q. Is it possible for you to perform the procedure without her admission to the hospital?

A. No, not as an out-patient.

You mean to do the surgery on an out-patient basis?

Q. Right.

A. No, not in this case would that be possible, because of her lifestyle.

Q. So, at this point your patient has not yet received the treatment you recommended for her?

A. That's correct.

Q. Can you think of other examples in your experience of persons who have been unable to get into hospitals when you tried to get them in?

A. Yes, I can.

One was in an automobile accident and was later bleeding to death, and his story was he had been to all of the surrounding hospitals southeast of us, including Nashville.

He had been refused and finally wound up in our emergency room with no blood pressure and literally bleeding to death at the time we took him in. We just had no choice, and he was an indigent patient, and thank goodness he is now living.

Q. Do you have any idea how many hospitals he had been to before he came to Perry County?

A. His story was that he had been to four.

Q. Okay. Can you think of other examples?

A. There is one other example that I can remember; a lady who had an intermittent partial bowel obstruction, and she needed surgery, and this had to be delayed for several months until she got her Medicaid back. In other words, until her Medicaid year was out. Then we admitted her and did her surgery and she is doing okay.

Q. Okay. Any other examples you can think of?

A. Not right offhand, except I remember one with lukemia who was severly ill. His blood count was in the area of four to five hemoglobin, and he had acute lymphocytic leukemia, and I remember one of the residents at Vanderbilt was here that weekend working for me, and we tried to get this patient into hemotology in Nashville. Since he worked there, he thought he could do it, but he hit the same brick wall I did.

He didn't have any money. Therefore, we better wait until we can get something done. So, I carefully explained this to the hemotologist, that I would have to transfer him and get the necessary studies and blood smears.

Anyway, this man was an acute lymphocytic leukemia patient, and I tried to get him in to one of the medical centers in Nashville, and the resident who was working for me that weekend thought he could get him in Nashville without any problem. He had the same answer that I got; since he has no money and no way to reimburse, we just can't take him.

So, I explained to the hemotologist that if I get the tests that you need or want and preserve the blood and send it to you and if I get this patient on Medicaid, will you accept him and treat him then? Of course, the answer was yes.

So, I went ahead and put him in the hospital here, transfused him, and got the tests prior to the transfusions, and got him to be transferred and did get him on Medicaid, and he was admitted to Vanderbilt.

After he was admitted, several of the specialty consultants, the hemotologist, internist, oncologist, made the statement, "This local doctor screwed up the tests," because I gave him blood transfusions, and it kind of gave the family a hassle because he had been treated prior to admission and, therefore, they were at a disadvantage, technically, as to what drugs to give this type cancer, and I had done everything they had told me to do, because they made such statements about my care. All I was trying to do was try to take care of a patient.

He was refused because of lack of money.

Q. How would you characterize the ability of people without remaining Medicaid days to get into hospitals?

A. I would say it is a hassle.

If you go ahead and admit them, I get notes put on the patient's chart. I get calls from the business office, various and sundry from the hospital, stating now, you know this person doesn't have any more Medicaid days and we are losing money on this patient, so we need to try to make some arrangements. Maybe you can refer him to a facility where they take care of indigent people, and it is strictly, it seems to me, more a money matter than it is a treatment matter.

Q. Is it your experience that there are people who do not get into the hospital because they have no remaining coverage?

A. Yes, it is. They are delayed. At least they are delayed until Medicaid is reinstated.

Q. Is it due to Medicaid?

A. That's right.

Q. Do you have less difficulty getting admission for a person with some reamaining Medicaid?

A. No problem at all if they have a few days left....

• • •

Cross Examination

* * *

By Mr. Scanlon:

Q. Doctor, I believe you mentioned four patients that you indicated you recall having difficulty getting into the hospital. I would like to ask some questions about those four.

First of all, you indicated that there was a woman, I believe, who needed some minor surgery and her number of Medicaid hospital days for that year had expired. Could you tell me what the condition was that you tried to admit her to the hospital for?

A. She had a chronic ulcer on the left knee, which had been preceded by chronic arthritic condition or chronic painful knee.

She had had orthopedic surgery done on the knee at times, too, and because of her poor standard of living—I am talking about filthy situations—it is just impossible to do anything to that girl and have her get well at home, because she cannot, under the circumstances keep her leg immobolized, which it would have to be for several days if this ulcer were to be repaired or excised and closed.

Q. Now, Doctor, that particular patient, she was on Medicaid at the time you tried to get her in the hospital, is that correct?

A. That's correct.

Q. All right. You recall when, approximately, it was that this situation occurred?

A. I would just roughly say four to six weeks ago.

Q. All right. Now, the second individual you indicated had trouble getting in the hospital was somebody trying to get some emergency treatment, is that correct?

A. Is this the man that was in the car wreck?

Q. Yes, sir.

A. That's right. He was out of the county. I believe Lewis County, perhaps Hickman County. I am not sure.

This happened four, five, six years ago.

Q. Was this four, five, six years ago, Doctor?

A. Yes.

Q. Was this individual a Medicaid recipient?

A. I don't know. I can't recall whether he was or not.

Q. Then there was a third individual you talked about, and correct me if I am not pronouncing this correctly, an intermittent partial bowel obstruction?

A. Yes.

Q. When did this situation occur?

A. That was about a year ago.

Q. Was this individual a Medicaid patient?

A. A Medicaid patient, that's correct.

Q. You couldn't get her into the hospital?

A. Well, I think I could have, if I had been insistent, but it would have been with a great deal of reluctance on the part of the hospital.

Frankly, I think it would have affected her care. As you know, a surgical patient has to have primary things concerning post operative care, and I felt that under the circumstances it would be better for her to be delayed, even though she was not completely obstructed bowel-wise. That is, her bowel was not completely obstructed. She can live, in other words, without surgery, but she would be much better off after the surgery, which she has been.

I felt if I had been insistent, that they probably would have treated her with a great deal of reluctance.

I tried to get her in Nashville at other hospitals, but they simply would not take her because she didn't have any money and was not a life threatening situation.

Q. Doctor, you mentioned a leukemia patient, and I was a little bit confused about that testimony.

You attempted, as I take it, initially, to take this patient into a hospital in Nashville, is that correct?

A. Yes, because I am not a hemotologist.

Q. At the time you initially attempted to get him into the hospital, was he a Medicaid patient?

A. No, he was not.

Q. All right. I believe you said you subsequently got him on Medicaid, is that correct?

A. That's true. He took the patient after that.

Q. All right. Doctor, outside of these instances that you recall, and I take it that there might be some that you don't recall—outside of these instances you are having trouble getting Medicaid people into the hospital, isn't it true that you normally don't have a problem getting Medicaid patients into the hospital?

A. If they have some days left. If they have a few days left, there is no problem, but I always get a note telling me how many days we have got to deal with the patient, and try to make arrangements to get them to some other facility or get them well enough to go home so that they won't be in the hospital for so-called uncovered days.

Q. Doctor, the point I was trying to make—and I understand and appreciate your testimony in that regard—but isn't it true

that most of the time the Medicaid patients that you put in the hospital do have days remaining?

A. I would say so, yes, sir.

MR. SCANLON: All right. Doctor, thank you very much. I don't have any further questions.

* * *

PLAINTIFFS' EXHIBIT P-4

April 14, 1980

Mr. William H. Thomas, Director
Office for Civil Rights
Department of Human Resources
Region IV
101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Thomas:

Enclosed for your review are copies of the following information requested in your letter of April 1, 1980:

(1) Revised Methods of Administration for Title VI and Section 504

(2) Updated Non-discrimination Policy

(3) Revised Mailing List

(4) Revised Title VI Compliance Review Procedure

(5) Information to be Distributed to Employees, Vendors, etc. (in the process of being printed)

Ms. Carol P. Mitchell will serve as the Department's 504 Coordinator. A description of her duties appears in the Administration and Responsibility portion of the enclosures.

Our proposed date for implementation is July 1, 1980.

If there are questions about any of this information, please contact Ms. Mitchell at (615) 741-1614.

We look forward to hearing from you soon.

Sincerely yours,

EUGENE W. FOWINKLE, M.D.
Commissioner

EWF:SLM:ljc 2/10

POLICY STATEMENT

The Tennessee Department of Public Health reaffirms its policies to afford all individuals including the handicapped the opportunity to participate in Federal financial assisted programs.

Title VI, Section 601, of the Civil Rights Act of 1964 provides that:

> "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Therefore, the Tennessee Department of Public Health will not, because of race, color, or national origin:

1. Deny an individual the opportunity to participate in or benefit from any service, financial aid, opportunity, or other benefit for which he is otherwise qualified;

2. Provide any individual with service, financial aid, or other benefit which is different, or is provided in a different manner from that which is provided to others under its programs;

3. Subject any individual to segregation or separate treatment in any matter related to his receipt of service, financial aid, or other benefit;

4. Restrict an individual in any way in the enjoyment of services, facilities, or any other advantage, privilege, or benefit provided to others under its programs;

5. Treat an individual differently from others in determining whether he satisfies any eligibility requirement or other condition which a person must meet in order

to receive aid, care, service, or any other health service;

6. Deny or offer any person an opportunity different from that offered others in any program or service; or

7. Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

Section 504 of the Rehabilitation Act of 1973 provides that:

> "No qualified handicapped person shall, on the basis of handicap be excluded from participation in, be denied benefits, or be subject to discrimination under any program or activity which receives or benefits from Federal financial assistance."

It is therefore, the policy of the Department of Public Health, that any discriminatory acts against the handicapped will be prohibited.

Discriminatory actions against the handicapped which should be prohibited are outlined below:

1. Deny a qualified handicapped person the opportunity to participate in or benefit from aid, benefit, or service;

2. Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

3. Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

4. Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or

services that are as effective as those provided to others;

5. Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistant to an agency, organization, or person that discriminates on the basis of handicap in providing aid, benefit, or service to beneficiaries of the recipients program;

6. Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

7. Otherwise limit a qualified handicapped person in the enjoyment of rights, privileges, advantages, or opportunities enjoyed by others receiving aid, benefit, or service.

ADMINISTRATION and RESPONSIBILITY

A. Commissioner

The Commissioner of Public Health is fully accountable and has overall responsiblity for Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 for the Department.

In addition, the Commissioner has the primary responsibility for the Tennessee Department of Public Health's adhering to the rules and regulations governing non-discrimination on the basis of handicap as well as to the anti-discrimination rules set by Title VI relative to race, color or national origin.

B. Title VI/Section 504 Coordinator

The Title VI and Section 504 Coordinator is responsible and accountable to the Commissioner for coordinating a comprehensive and complex Title VI and Section 504 program for the Tennessee Department of Public Health as mandated by the United

States Department of Human Resources. The Coordinator is responsible for ensuring that any program or activity which receives Federal financial assistance adheres to the regulations governing Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 19733 are actively approached and difficulties in meeting the terms and conditions are eliminated.

The responsibility, limitations and authority vested in this position include the following:

1. Disseminate information concerning the Department's obligation under Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 which include Departmental Regulations, Statement of Compliance, and Method of Administration as well as training sessions, written material, meetings, notices and public announcements.

2. Maintain and review reports on initial and annual reviews of the Department's own operations, vendors, contractors, and other providers of services to assure compliance with Title VI and Section 504.

3. Receive and investigate all Title VI and Section 504 complaints from applicants, recipients, and other interested parties. When Title VI and Section 504 violations or deficiencies are validated, the Coordinator will assure prompt and corrective actions are taken. If compliance cannot be negotiated, the respective vendor, contractor, or other provider of service will be terminated from participation in the Department's program.

4. Act for the Department in Title VI and Section 504 matters with staff, other state agencies, local governments, providers or recipients of departmental program services, the general public and Federal agencies.

5. Assure that contracts or agreements are not negotiated with non-complying vendors such as doctors, hospitals, nursing homes, etc. Also, taking steps to assure that referrals are not made to noncomplying facilities, agencies, or other providers of service.

6. Apprise the Commissioner on a quarterly basis of all activities conducted and actions taken relative to Title VI and Section 504. The report will reflect the findings, actions required and results of the follow-up on each hospital, nursing home, physician's office review conducted during the quarter.

7. Maintain files and records relating to Title VI and Section 504.

C. **Title VI and Section 504 Reviewer**

The responsiblity, limitations and authority vested in this position include, but are not limited to, the following:

1. Disseminate the Department's non-discriminatory policy to all Department employees, doctors, hospitals, nursing homes, regional health offices, other contracted service agencies, and the general public.

2. Assure that all services and benefits of Federally assisted programs are not denied because of race, color, national origin or handicapped condition.

3. Make certain that complaint forms and procedures are available to vendors and contracted service agencies.

4. Review all complaints, whether received verbally or in writing and resolved or unresvoled, and prepare for disposition.

5. Conduct on-site reviews of designated facilities for Title VI and Section 504 compliance status.

D. **Regional Health Department Coordinator**

It shall be the responsiblity of the Regional Health Department Coordinator to assure that county and local health departments within their region are in compliance with Title VI and Section 504. The Title VI and Section 504 Coordinator will provide the necessary technical assistance, written material, notices, announcements and forms in order to effectively assure compliance of county and local health departments.

Each regional health department will have a designated Coordinator. The responsibility, limitations, and authority vested in this position includes, but are not limited to, the following:

1. Disseminate Title VI and Section 504 information to all local health department employees and clients;

2. Conduct on-site reviews annually on local health departments for Title VI and Section 504 compliance status. These reviews will be conducted by the Regional Coordinator.

3. Observe and assure that practices of the local health departments are in compliance with Title VI and Section 504 guidelines.

4. Orient staff in local health departments to Title VI and Section 504 regulations and responsibilities.

5. Assure that referrals for service are not made to facilities or individuals who are known to be in non-compliance with Title VI and Section 504.

6. Document that local health departments work with the public on a non-racial basis.

7. Transmit, in writing, all Title VI and Section 504 complaints to the Title VI/Section 504 Coordinator.

8. Complete periodic reports which will contain data applicable to Title VI and Section 504 compliance mat-

ters. This information shall be forwarded to the Title VI/Section 504 Coordinator on a monthly basis.

DISSEMINATION OF INFORMATION

The following methods will be utilized to advise Tennessee Department of Public Health employees, all local health department employees, applicants and recipients of services, and vendors apprised of the requirements of Title VI and Section 504 and all the rights and responsibilities that it assures:

INTERNAL:

1. An in-service training program for all Regional Health Department Coordinators with yearly maintenance technical assistance to be provided by the Title VI and Section 504 Coordinator.

2. An in-service training program concerning Title VI and Section 504 will be provided by the Regional Coordinator on a yearly basis to all new county and local health department employees.

3. The distribution of Title VI and Section 504 packets to all new employees. This information will be distributed during "New Employee Orientation" by the Division of Personnel, Recruitment and Training.

4. Training will be provided to any employee who has direct responsibility relative to Title VI and Section 504.

5. The distribution of the Department's non-discriminatory policy and posting the policy in a conspicuous place within all departmental facilities.

EXTERNAL:

1. Include in all contracts for service a Title VI and Section 504 policy statement.

2. Provide all information concerning the Tennessee Department of Public Health's non-discriminatory policy regarding Title VI and Section 504 to vendors, clients, recruiting sources and the general public as well as providing copies for all vendor facilities for posting.

3. Provide nursing homes, hospitals, physicians' offices and other contracted service facilities with policies, guidelines, complaint procedures and forms, brochures and other informational materials relative to Title VI and Section 504.

MAINTAINING AND ASSURING COMPLIANCE

The following methods will be utilized for maintaining and assuring compliance with Title VI and Section 504 in facilities receiving Federal financial assistance.

I. Regional Health Departments

Maintaining and assuring compliance in regional health departments will be accomplished in the following manner:

A. Each regional health department will have an assigned Regional Coordinator with the duties and responsibilities outlined in a previous section of this document.

B. On-site reviews will be completed by the Regional Coordinator annually for those local health departments within that region.

C. Quarterly reports will be completed by the Regional Coordinator which will contain data applicable to Title VI and Section 504 compliance status.

II. Hospitals and Clinics

Maintaining and assuring compliance for hospitals and clinics which receive Federal financial assistance through the Tennessee Department of Public Health will be accomplished in the following manner:

A. Annually hospital compliance information will be mailed to hospitals for completion and returned to the Department. The information will be reviewed for compliance purposes. If no questionable data is found, approval for compliance will be provided. If, however, questionable data is provided the Bureau of Medicaid Administration, Division of Health Care Facilities/Quality Assurance, will be requested to obtain specific data during their on-site reivew. (See Attachment I). Review findings will be forwarded to the Civil Rights Coordinator to ascertain compliance status. After review of the information, the facility will be requested to take steps to resolve all deficiencies or violations. The hospital must submit written documentation, within a pre-established time frame, to substantiate that corrective actions have been taken. If compliance issues cannot be corrected, compliance will not be granted and appropriate personnel, State agencies and OCR will be notified.

B. In those hospitals where Medicare and Medicaid compliance is necessary a joint effort between the Office for Civil Rights and the Tennessee Department of Public Health will be conducted. The Office for Civil Rights will conduct initial reviews of all hospitals which participate in Medicare and Medicaid. Compliance documentation of hospitals reviewed will be exchanged between the TDPH and OCR.

C. On-site and/or desk audits will be completed on those hospitals which are identified by complaints, violations or other pertinent information by the Department if the OCR has no current information on the matter.

D. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is agreed upon in writing. All appropriate personnel, State agencies and OCR will be notified of this matter by the Civil Rights Coordinator. The Department will provide a 120 day time frame in which facilities can respond, negotiate and resolve issues cited in the review.

III. Nursing Homes

Maintaining and assuring compliance for nursing homes which receive Federal financial assistance will be accomplished in the following manner:

A. Annually 20% of the nursing homes located in counties with more than 10% minority population and 5% of the nursing homes located in counties with less than 10% minority population will have on-site reviews conducted by the Bureau of Medicaid Administration, Division of Health Care Facilities/-Quality Assurance, during the regular review process. The team will be provided with a review form (See Attachment II) designed and approved by the OCR. Other information will be forwarded to the facility for completion prior to the on-site review. All information will be returned to the Civil Rights Coordinator by the team for review and response, and pending, compliance, or non-compliance status will be provided.

B. Annually nursing home compliance information will be mailed to the remaining 80% of the nursing homes for completion and returned to the Department. The information will be reviewed for compliance purposes. If no questionable data is found, approval for compliance will be provided. If, however, questionable data is provided, the facility will be requested

to take steps to resolve all deficiencies or violations. The facility must submit written documentation, within a pre-established time frame, to substantiate that corrective actions have been taken. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is agreed upon in writing. All appropriate personnel, State agencies and OCR will be notified of this mater by the Civil Rights Coordinator.

C. Title VI and Section 504 documentation on the review of nursing homes which jointly participate in Medicare and Medicaid will be exchanged between the Department and OCR.

D. On-site audits will be completed on those nursing homes which are indicated by complaints, reported violations or other information. The Department will provide a 120 day time frame in which facilities can respond, negotiate and resolve issues cited in the review.

IV. Physicians and Dentists

Maintaining and assuring compliance for physicians and dentists which receive Federal financial assistance will be accomplished in the following manner:

A. Information packets will be distributed to *all* physicians, dentists, and others of the healing arts that participate in the Medicaid program. The packet will include Title VI and Section 504 regulations, signs or posters indicating non-discriminatory policies and other pertinent information.

B. Annually 10% of the medical professionals who receive $25,000 and above will be reviewed for Title VI and Section 504 compliance.

C. A review of data from the "Surveillance and Utilization Review" provided by the Bureau of Medicaid Administration will be completed by the Civil Rights Coordinator on a quarterly basis. The review will identify provider, number of patients seen, number of visits per patient, number of patients hospitalized, kinds of medical services conducted, cost per service and other information. The information will be retrieved on providers which appear to have discrepancies in comparison to their medical counterparts and will be utilized for requiring an on-site audit by Medicaid program personnel or the Civil Rights Coordinator.

D. On-site and/or desk audits will be conducted when complaints, violations or other data indicate. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is met. Other State agencies and the OCR will be notified.

COMPLAINTS

The following methods will be utilized for handling Title VI and Section 504 complaints:

1. All information necessary for filing a complaint will be posted throughout the Department;

2. All information necessary for filing a complaint will be provided in pad form for those individuals who want to take the information with them. (See Attachment III).

3. Individuals who wish to file a complaint will be assisted in completing the required data if they so request;

4. Complaints may be resolved at the point where it is filed when filed verbally or in writing. However, a report or complaint, even if verbal, must be submitted in writing to the Department by the area receiving the complaint;

5. The Civil Rights Coordinator will investigate and resolve those complaints which are not handled at the originating point as indicated;

6. Complainants will be advised of the option of filing complaints with the Department, Regional Office, and/or the Regional Office for Civil Rights (Atlanta, Georgia).

7. Resolutions of complaints will be provided to the complainant;

8. All complaints will have an initial or preliminary investigation within at least 60 days after complaint is received;

9. A record of all complaints and their resolutions will be maintained by the Civil Rights Coordinator and will be available for review by the Office for Civil Rights upon request at any time during the Department's normal business hours;

10. The Department may request the complaint be investigated by other personnel when appropriate;

11. If complaints are valid and a Title VI or Section 504 compliance issue continues to exist, negotiations with those providers of service will be made by the Department in an effort to resolve the matter;

12. If complaints, which identify a valid Title VI compliance issue, cannot be resolved then the Department will take the appropriate action as outlined in the

MAINTAINING AND ASSURING COMPLIANCE section of this document;

13. The Department will advise the Office for Civil Rights of complaints which are received and of the action taken.

RECRUITMENT AND TRAINING

The Department will take the following action to assure that all recruitment and training programs of the Tennessee Department of Public Health are administered in such a way as to assure equal opportunity regardless of race, color, or national origin:

1. Assure that the AAP as adopted by the Department is being followed as well as assure that facilities receiving Federal financial assistance personnel policies are not discriminatory.

2. Review training and employment reports in an effort to ascertain minority participation.

3. Advise the Commissioner of the TDPH on any adverse action indicated through information obtained by observation.

PLAINTIFF'S EXHIBIT P-10

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights

Region IV
101 Marietta Tower
Atlanta, GA 30323

November 21, 1980

Eugene W. Fowinkle, M.D.
Commissioner
Tennessee Department of Public Health
Bureal of Medicaid Administration and
Coordination
344 Cordell Hull Building
Nashville, Tennessee 37219

Complaint #04-80—3154

Dear Dr. Fowinkle:

As you know, the Office for Civil Rights (OCR) is in receipt of a complaint filed by Mr. Gordon Bonnyman of the Legal Services of Middle Tennessee, Inc. Mr. Bonnyman alleges that certain proposals to reduce services under the Medical Assistance Program under Title XIX of the Social Security Act will have an adverse effect upon minority and handicapped persons in violation of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, respectively.

Pursuant to 45 C.F.R. §80.7 of the regulations promulgated under Title VI of the Civil Rights Act and 45 C.F.R. §84.61 of the regulations promulgated under Section 504 of the Rehabilitation Act, OCR must conduct a prompt investigation of this complaint. To that end, the enclosed data request is submitted for your review and completion.

The data request was designed after consultation with the Health Care Financing Administration and is compatible with data available through the Tennessee Medicaid Management Information System (MMIS). In order to clarify and respond to any question you may have regarding the data request, we would like the opportunity to meet with you within the next ten (10) days. We request that the meeting also include members of your staff and representatives from the fiscal intermediary, Electronic Data System Federal Corporation, who are familiar with the MMIS. Ms. Narris Kennebrew of my staff will be contacting you to arrange a meeting date and time.

The state's response to the OCR data request must be forwarded to Ms. Marie Chretien, Division Director, no later than 30 days after the meeting to be scheduled between our two staffs.

Your cooperation in this matter is appreciated. Should you have any questions, do not hesitate to contact either Ms. Marie Chretien, Division Director, or Ms. Narris Kennebrew, Equal Opportunity Specialist, at (404) 221-5962.

Sincerely yours,

/s/ Carolyn J. Russell
Regional Director
Office for Civil Rights

DATA REQUEST

The Office for Civil Rights has obtained a copy of the state's current "State Plan for Medicaid Assistance Plan Under Title XIX of the Social Security Act," as well as state plan materials which were obsoleted during 1978, 1979 and 1980. These materials were obtained from the regional office of the Health Care Financing Administration. In responding to this data request, where appropriate, please specify the pertinent section of the state plan, including the effective date of the relevant section.

1. Please provide a description of the following:

   a. **Number of Medicaid Eligibles by Eligibility Category By Race and By Handicap***: For fiscal year 1980 describe the number of Medicaid eligibles by race, by handicap and by type of eligibility category. For each such type and category, describe any changes in eligibility standards during fiscal year 1980. The term eligibility standard includes changes in income limits, resource limits, or bases of deprivation under the AFDC program.

   b. **Scope of Services:** List all mandatory and optional services included in the state Medicaid Program, and indicate whether it is available to the categorically needy and/or medically needy. For each such service describe the present scope of said service, as well as any additions, deletions, or limitations imposed on each such service during fiscal year 1980.

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* For purposes of this data request, the term "handicap" refers to the following categories: those individuals who are eligible for the Medicaid program because they are either (1) blind or (2) disabled, or have a physical or mental handicap or disability such as (3) ~~these persons receiving drug and alcohol treatment, or~~ (4) those persons in ICFs *or SNFs over age 65* and (5) ~~handicapped~~ children, *under 21 in ICF-MRs,* ~~identified under the EPSDT program.~~

With regard to Medicaid services provided under the drug formulary, indicate whether the state has imposed a limit on the number of refills, or a minimum or maximum quantity which may be received by a beneficiary for (i) beneficiaries residing in an ICF and (ii) other beneficiaries.

c. **Reimbursement:** For each service set forth in your response to question 1b, describe the present level and methodology for providing remibursement for each such service, as well as any changes in either the level or methodology which occurred during fiscal year 1980. Has the state made any determination of the extent to which its level of reimbursement for each such service is sufficient to provide Medicaid recipients with access to each such service at least equivalent to that enjoyed by the general population? If the answer to the foregoing question is in the affirmative, then provide any documentation which supports such a determination.

d. **Administration:**

(i) For each such service identified in question 1b, is the service presently subject to prior authorization? If the answer to the foregoing question is in the affirmative, describe the present prior authorization procedure applicable to each such service, as well as changes implemented during fiscal year 1980. Identify by race and handicap the number of persons subject to the prior authorization requirement during each month in fiscal year 1980.

(ii) During fiscal year 1980, did the state use a lock-in procedure for Medicaid recipients? If the answer to the foregoing question is in the affirmative, describe the lock-in procedure, as well as changes implemented during fiscal year 1980.

Identify by race and handicap the number of persons subject to lock-in during each month in fiscal year 1980.

(iii) For each of the services identified in question 1b,is the service presently subject to a post-service review? If the answer to the foregoing question is in the affirmative, describe the present post-service review procedure applicable to each such service. Identify any changes in the post service review procedure applicable to each such service in fiscal year 1980. Identify by race and handicap the number of persons subject to the post-service review during each month in fiscal year 1980.

2. Please describe each proposed Medicaid reduction to be implemented in fiscal year 1980-81. The description should include, but is not limited to the following:

(a) **Scope of Services:** For each type and category of service scheduled for reduction, describe the scope of services to be provided under the proposal; as well as any deletions, additions, or limits to be imposed.

(b) **Reimbursement:** For each service set forth in your response to question 2a, describe the level and methodology which will be used to determine reimbursement for each such service. Has the state determined the extent to which this level of reimbursement will sufficiently provide Medicaid beneficiaries with access to each such service at least equivalent to that enjoyed by the general population? If the answer to the foregoing question is in the affirmative, please provide any documentation which supports such a determination.

(c) **Administration:** For each such service identified in question 2a, will said service be subject to a prior authorization, lock-in, or post-service review procedure? If the answer to any part of the foregoing question is in the affirmative, describe the procedure.

3. (a) With regard to each reduction set forth in question 2(a), please state the objective to be served by they proposed reduction in service. If the objective is fiscal savings, please specify for each proposed reduction the amount to be saved and the time period over which said savings will be realized.

(b) When was the decision made to implement the proposed reductions? By whom? Are there reports, memorandums, minutes of meetings, or other documents regarding how the decision was made? If so, please specify and provide copies.

(c) What factors were considered and what conclusions were reached?

(d) Did the Tennessee Department of Public Health, or any other agency or empioyee of the state of Tennessee consider the effects of the proposed reduction in services on minorities and handicapped persons? If so, what were the findings? What methodology was utilized to project the effects? When were the findings made? Were any written reports generated by these findings? If the answer to any of the foregoing is in the affirmative, please specify and provide copies.

(e) What options were considered for changes other than those specified proposals set forth in question two above. For each option, state why the option was rejected, and the extent to which implementation would have realized the objective set forth in answer to question 3a.

4. (a) For each of the following Medicaid services: inpatient services, outpatient services, emergency care services, clinic services, and physician's services provided in a physician's office, complete the attached tables* requesting beneficiary utilization data of services for fiscal year 1980 by county**, for the state, by race and by handicap.

   (b) For fiscal year 1980, indicate by race the number of Medicaid eligibles who were 65 years of age or older.

5. For fiscal year 1980, please provide the following data by completing chart 6:

   (a) The total number of beneficiaries by race and by specified county who have and for the state who have been certified for ICF admission.

   (b) Of those persons certified, the number of beneficiaries by race and by county who:

      (i) have been admitted to ICF's;
      (ii) are in board and care facilities;
      (iii) are receiving home health services;
      (iv) are receiving other services; or
      (v) are receiving no services.

6. Of those persons certified and currently in ICF's, how many beneficiaries by race and on a statewide basis are:

      (i) categorically needy; and
      (ii) medically needy Medicaid beneficiaries.

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* Inpatient services, chart #1 and #1(a); outpatient services, chart #2 through #2(c); emergency care services, chart #3 and #3(a); clinic services, chart #4 and #4(a); and physician's services provided in a physician's office, chart #5 and #5(a).

** For purposes of this data request, data by county will be requested for only Davidson, Hamilton, Knox, Shelby and Sullivan Counties.

7. For fiscal year 1980, indicate for each drug proposed to be deleted in the formulary the number of Medicaid beneficiaries by race and handicap who received each such drug, the quantity received, and amount expended in each drug category.

8. For each drug proposed to be eliminated from the drug formulary, identify the alternative drug or service the state has determined may be substituted.

9. Please indicate:

   (a) The number of physicians in active practice in the state;

   (b) The number of physicians participating in the Medicaid program;

   (c) By county, the number of physicians who have submitted the number of claims specified in chart #7 for services rendered in a physician's ofice.

10. The Office for Civil Rights has obtained a copy of the state agency's current Title VI Methods of Administration Plan. Please describe any changes which may have been adopted since its submission to this office in April 1980.

11. Describe all efforts undertaken to implement the Title VI Methods of Administration, particularly with regard to the monitoring of skilled nursing and intermediate care facilities and nursing home utilization. When were these efforts taken and what were the results?

12. Please provide a copy of the current claims form used by providers to bill the state for medical services, and provide copies of any other versions of the claims form that were in effect during fiscal year 1980.

EDITOR'S NOTE

PAGES 154 through 167 WERE POOR HARD COPY AT THE TIME OF FILMLNG. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

Chart 1: Total Number of Inpatients Per Beneficiary By Race and By County for Fiscal 1980

		RACE			
COUNTY		Black	White	Other	Total
Davidson	Number of Inpatient Days Per Year				
	1-14				
	15-20				
	21 or more				
	TOTAL				
Hamilton	1-14				
	15-20				
	21 or more				
	TOTAL				
Knox	1-14				
	15-20				
	21 or more				
	TOTAL				
Shelby	1-14				
	15-20				
	21 or more				
	TOTAL				
Sullivan	1-14				
	15-20				
	21 or more				
	TOTAL				
Statewide (95 County) Total	1-14				
	15-20				
	21 or more				
	TOTAL				

Handicap for Fiscal Year

COUNTY		HANDICAP. Blind	Disabled	Drug and Alcohol	Handicapped Children.	Other (Please Specify)	TOTAL
	Number of Inpatient Days Per Year						
	1-14						
Davidson	15-20						
	21 or more						
	TOTAL						
	1-14						
Hamilton	15-20						
	21 or more						
	TOTAL						
	1-14						
Knox	15-20						
	21 or more						
	TOTAL						
	1-14						
Shelby	15-20						
	21 or more						
	TOTAL						
	1-14						
Sullivan	15-20						
	21 or more						
	TOTAL						
	1-14						
Statewide (95 County) Total	15-20						
	21 or more						
	TOTAL						

PLAINTIFF'S EXHIBIT P-24

Health Characteristics Of Persons With Chronic Activity Limitation

United States 1974

Table 9. Number of hospital days and average length of stay for discharges from short-stay hospitals, by chronic activity limitation status, sex, and age: United States, based on data collected in health interviews in 1974

Sex and age	Total population	With no limitation of activity	With limitation of activity			
			Total	Limited but not in major activity[1]	Limited in amount or kind of major activity[1]	Unable to carry on major activity[1]
	Number of hospital days in thousands					
Both sexes						
All ages	248,345	109,807	138,408	12,717	52,066	71,625
Under 17 years	38,313	18,588	9,726	*	1,088	3,809
17-44 years	82,148	49,317	32,832	3,712	14,586	14,166
45-64 years	76,318	28,454	48,866	4,487	30,581	34,427
65 years and over	81,565	13,579	47,566	3,719	15,042	20,226
Male						
All ages	118,890	43,070	75,819	5,419	18,874	50,326
Under 17 years	18,620	11,397	4,223	*	*	2,226
17-44 years	30,880	14,384	16,496	1,430	5,893	9,163
45-64 years	43,982	12,087	31,896	3,074	9,809	20,173
65 years and over	38,267	5,183	33,084	1,816	3,743	17,525
Female						
All ages	129,896	66,837	60,799	7,298	32,193	21,206
Under 17 years	9,693	8,190	1,502	*	*	5,042
17-44 years	51,269	34,933	16,376	2,281	9,022	4,253
45-64 years	32,346	14,357	18,009	2,303	11,272	11,400
65 years and over	33,296	8,396	24,902	2,303	11,299	
	Average length of stay in days					
Both sexes						
All ages	8.4	8.9	12.4	8.7	10.2	16.2
Under 17 years	8.7	4.8	12.1	*	8.3	30.8
17-44 years	8.8	8.3	11.8	8.8	10.8	19.2
45-64 years	10.2	7.8	13.8	8.8	10.8	16.1
65 years and over	11.7	8.2	12.7	11.8	10.8	14.3
Male						
All ages	8.8	8.4	14.1	8.2	11.2	16.8
Under 17 years	8.5	8.3	17.1	*	*	47.4
17-44 years	8.8	8.8	14.3	7.1	11.8	21.1
45-64 years	11.8	7.8	14.7	8.3	13.4	17.3
65 years and over	11.7	8.8	12.8	14.4	10.3	13.3
Female						
All ages	7.4	8.7	10.8	8.3	8.7	14.8
Under 17 years	4.8	4.8	8.8	*	*	*
17-44 years	8.8	8.1	10.1	8.8	8.3	16.8
45-64 years	8.8	7.2	10.8	8.8	8.4	12.1
65 years and over	11.8	8.8	12.8	10.1	10.7	16.8

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.

PLAINTIFF'S EXHIBIT P-25

Characteristics, Social Contacts, and Activities of Nursing Home Residents

United States
1973-74 National Nursing Home Survey

Figure 1. Percent of nursing home residents by sex, age, and marital status: United States, 1973-74

paring nursing home residents to the noninstitutionalized population. Nursing home residents are an elderly population; most (89 percent) were 65 years of age or older, and 38 percent were 85 years of age or older (table 1). The mean age for residents was 79.

Another characteristic of nursing home residents which was similar to that found in earlier surveys is the large proportion of widows and widowers. A greater proportion of the residents were widowed than were married, divorced, separated, or never married. Furthermore, between the ages of 65 and 90 the proportion of residents who were widowed increased directly with age. From age 90 the proportion of nursing home residents who were widowed leveled off. An important distinction, however, is found when marital status of male and female residents is compared—75 percent of the women were widowed compared to only 42 percent of the men. From the opposite point of view, only 8 percent of the women had a living spouse who could presumably visit them or be responsible for them away from the facility, while 22 percent of the men had a living spouse.

When marital status is examined by characteristics of the facility, there are differences by region and certification status. A somewhat greater proportion of residents living in facilities in the Northeast and North Central Regions than of those living in the South or West had never been married. Also, a greater proportion of those in uncertified facilities than of those in certified facilities had never been married (table 2).

Race or Ethnicity

The 1973-74 National Nursing Home Survey shows greater detail on race or ethnicity than the earlier NCHS surveys did. The question on resident's race or ethnicity was as follows:

What is (name) ethnic background? (Mark (X) only one box)

- ☐ Caucasian
- ☐ Negro
- ☐ Oriental
- ☐ Spanish American
- ☐ American Indian
- ☐ Other

Only one answer category was permitted for each resident. Because of this feature of the questionnaire, racial background of the Spanish American residents was not obtained. Therefore in this report "white" refers exclusively to those residents for whom the category "Caucasian" was checked. Whenever cell size permits, detail on the other racial or ethnic groups is shown separately.

Table A shows the number of nursing home residents by racial or ethnic group. Most of the residents were white (excluding Spanish Americans), which is true of the American population

Table A. Number and percent of nursing home residents by race or ethnicity: United States, 1973-74

Race or ethnicity	Number	Percent
All residents	1,079,800	100.0
White[1]	1,018,400	93.9
Black	48,300	4.8
Spanish American	13,000	1.1
Other	4,200	0.4

[1] Excludes Spanish American.

PLAINTIFF'S EXHIBIT P-26

DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES

1979 EDITION
(Revised)

Medicaid/Medicare Management Institute

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Baltimore MD 21235
1979

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX, JANUARY, 1979

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
[illegible]	30 days per calendar year	Preauthorization required	Preauthorization required	1 visit per month elsewhere for chronic stable illness; 1 visit per day in hospital.
[illegible]	Nonemergency out-of-State hospitalization requires preauthorization.	Preauthorization required	Preauthorization required	Elective (cosmetic) surgery requires preauthorization.
[illegible]	Limited to 30 days per calendar year with provision for extension based on medical necessity and with prior authorization.	Prior authorization required	No limitations	18 visits per calendar year in physician's office, patient's home or nursing home. For hospital emergency room visits, 12 per calendar year.
[illegible]	Subject to prior authorization and specified length of stay as approved.	Subject to preadmission authorization and periodic reauthorization.	Subject to preadmission authorization and periodic reauthorization.	Subject to prior authorization for more than eight psychiatric visits or eight allergy hyposensitization visits in a 120-day period. Services for cosmetic purposes not covered. Prior authorization required for sterilization services.
[illegible]	Services provided as long as is medically necessary. Emergency hospital services provided when necessary to prevent death or serious impairment of health, even though hospital may not meet conditions for participation under Title XVIII.	No limitations	No limitations	No limitations.
[illegible]	Prior authorization is required beyond 10 days.	Initial review to determine level of care made by a medical consultant within 14 days of patient's admission to a facility. Periodic patient reviews are made thereafter by a team to determine continued need for skilled nursing services.	Level of care is determined within 14 days of patient's admission to facility and the need for continued care in the facility is periodically redetermined thereafter.	Prior authorization required for services to patients in skilled nursing facilities beyond 1 visit per month for chronic conditions and 5 visits per month for acute conditions.
[illegible]	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
North Carolina	Prior authorization required for admissions for cosmetic surgery and surgical transplants except bone, tendon and renal transplants.	Prior approval required	Prior authorization required	Routine physical exams and routine screening tests are excluded except for EPSDT recipients and an annual examination allowed for recipients in homes for aged, skilled nursing and intermediate care facilities. Eye refractions are limited to 1 per year for recipients ages 24 and under, and 1 in 2 years for recipients ages 25 and over. Prior approval required for surgical transplants (except for bone, renal and tendon),, cosmetic surgery and more than 2 psychiatric visits.
North Dakota	No limitations	No limitations	No limitations	No limitations.
* Ohio	60-day limitation per spell of illness .	Physicians' certification and recertification required every 60 days.	No limitations. Persons must be in need of such care.	10 physician visits per month.
* Oklahoma	10 days per admission	Prior approval required	Preauthorization required	Limited to inpatient hospital visits and surgical services for a compensable hospital period; outpatient-4 office visits and/or 4 home visits per month per patient; and 2 visits per month in a nursing home.
Oregon	Limited to 21 days	No limitations	No limitations	Prior authorization required for elective and rehabilitative procedures.
Pennsylvania	Payment is not made for overnight or weekend passes in excess of 12 hours continuous absence and absence for purposes of employment or school. Payment is not made for prolonged hospitalization which is not medically justified.	No limitations	No limitations	Prior authorization required for all general and special medical examinations and consultations. Hospital inpatients—consultations limited to 1 per specialty per hospital admission; outpatient—consultation limited to 1 per 12 month period. $200 maximum amount payable to physician for his services provided during any 1 period of hospitalization or for a series of recurrent or related surgical procedures.

Puerto Rico	Limited to services provided in public facilities and 2 private facilities under contract.	Provided in public facilities	Not provided	Available through public facilities and some physicians under contract.
Rhode Island	Prior authorization required for stays in excess of 15 days per admission for persons under age 65, or in excess of 60 days for persons age 65 or older who are also covered by Medicare.	Prior authorization required for all admissions.	No limitations	Prior authorization required for visits in excess of 2 per month for chronic illness and in excess of 8 per month for acute illness; inpatient hospital visits in excess of 37 days up to maximum of 100 days, office visits provided by psychiatrists beyond initial evaluation visit.
South Carolina	40 days per Fiscal Year	Need for care approved or disapproved by PSRO.	Need for care approved or disapproved by PSRO.	Visits must be medically justified.
South Dakota	30 days per benefit period. 1st 3 pints of blood per benefit period.	No limitations	No limitations	Limited to services which are medically necessary and required by patient.
Tennessee	20 days per Fiscal Year	Prior authorization required	No limitations	Prior approval required for unusual elective types of surgical procedures.
Texas	30 days per spell of illness	Level of care determination is required	Level of care determination is required	No limitations.
Utah	No limitations	No limitations	No limitations	No limitations on number of visits for acute conditions, except psychiatric care is limited to 12 hours of treatment for each acute illness unless prior written approval for additional care is obtained.
Vermont	No specified day limitations	Authorization is required	Authorization is required	Treatment of mental, psychoneurotic or personality disorders limited to $500 per calendar year.
Virgin Islands	Prior authorization required	Service presently being developed. Prior authorization will be required.	Not provided	Limited to services provided by Health Department personnel; otherwise by prior authorization of the Bureau.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Kansas	All out-of-State inpatient care is subject to prior authorization except for emergency care and care within hospitals bordering Kansas, whose services are routinely utilized by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Saturday except in the case of an emergency admission.	No limitations	No limitations	Office calls are limited to 3 per month unless supported by written documentation confirming medical necessity. Adult care home visits are limited to 1 per month unless supported by written documentation confirming medical necessity. Surgery for cosmetic purposes is not payable. Abortions are provided when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident.
Kentucky	21 days per admission	Preauthorization required	Preauthorization required	Initial and extensive visits limited to 2 per patient per physician per calendar year. Preauthorization required for those patients "locked in" to 1 physician and 1 pharmacy, who require services in excess of 4 prescriptions and 4 physician office visits per month.
Louisiana	Care in a short term general hospital is limited to 15 days in a calendar year without prior approval. If a recipient requires hospitalization beyond 15 days, or readmission only when medically necessary home passes are required, a determination to extend hospitalization would be made.	No limitations	No limitations	Limited to 12 outpatient visits per year, with extensions subject to prior approval. Up to 15 inpatient visits including admission visits in any calendar year when recipient is hospitalized without surgery.
Maine	Prior authorization required for extension of hospital benefit days beyond 60 days. Intensive care and coronary care services do not require prior authorization.	No limitations	No limitations	No limitations.

Maryland	Preauthorization required	Preauthorization required for all initial nursing home admissions.	Preauthorization required for all admissions.	Preauthorization required for surgery normally considered cosmetic.
Massachusetts	No limitations	No limitations	No limitations	Preauthorization required.
Michigan	Minimum period necessary in type of facility for the proper care and treatment of patient.	Minimum period necessary in type of facility for the proper care and treatment of patient.	Provided based on level of care appropriate to patient's medical needs.	Visits in the nursing home setting are limited to 1 visit per patient per month; additional visits must be documented as medically necessary.
Minnesota	No limitations	No limitations	No limitations	No limitations.
Mississippi	40 days per Fiscal Year	Prior authorization required	Prior authorization required	Hospital visits—limited to 1 per day; nursing home visits—limited to 36 per Fiscal Year.
Missouri	21 days per admission	Prior authorization required	Prior authorization required	Limited to those that are medically necessary. Payment is not made for cosmetic surgery. Certain recipients who have over-utilized physician's services are limited to service of only 1 physician of their own choosing.
Montana	No limitations	No limitations	No limitations	No limitations.
Nebraska	Prior authorization required	No limitations	No limitations	No specified limitations.
Nevada	Limited to admissions designated in the Concurrent Review Screening manual.	Prior authorization required	Prior authorization required	Limited to 2 office visits per person per month for treatment of illness, 2 therapeutic injections per month and emergency treatment. Services to hospital inpatients are not limited.
New Hampshire	Requires prior approval for patients who are anticipated to require hospitalization for period longer than 12 days.	Prior authorization required	Prior authorization required	Limited to 1 visit per month per patient, except 1 visit per week for acute care SNF patients.
New Jersey	Limited by exclusion of elective cosmetic surgery and diet therapy for exogenous obesity.	Prior authorization required except where patient is transferred to nursing home directly from an acute care facility.	Prior authorization required	Prior authorization required for elective cosmetic surgery and podiatric treatment when costs exceed $300 in given year.
New Mexico	Abortions are provided under certain conditions.	No limitations	No limitations	Abortions are provided under certain conditions.
New York	No limitations	Prior approval except when admitted directly from hospital, another nursing home, or from health related facility.	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
District of Columbia	Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by State agency. services provided in connection with dental or oral surgery will be limited to those required for emergency repair of accidental injury to jaw and related structures.	Items and services furnished by skilled nursing facilities maintained primarily for care and treatment of inpatients with TB will be provided only for individuals 65 years of age or older.	No limitations	Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures. Surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by State agency. Ambulatory psychiatric care will be provided only in a formally organized psychiatric clinic which is approved as such by State agency, except when prior authorization for such care has been obtained from State agency.
Florida	45 days per patient per Fiscal Year	No limitations	No limitations	Excludes routine physicals and eye examinations, internal organ transplants which are considered experimental, clinically unproven procedures, and sterilization procedures for any person who has been judicially declared mentally incompetent, or who is under age 21, or who is legally incompetent under State law.
Georgia	Prior approval required for renal dialysis and/or kidney transplants except in cases of emergency dialysis.	Initial prior approval is required	Initial prior approval is required	Outpatient psychotherapy is limited to maximum of $250 per patient per calendar year. Unless medically justifiable need for exception exists, home and office visits limited to 1 per month, nursing home visits limited to 1 per month, and hospital visits limited to 1 per day.
Guam	A Medicaid recipient may not be confined for more than 65 consecutive days at a semi-private rate. If confinement is medically necessary after this period of time, then a reduced room rate equal to a SNF must be utilized. Only first 3 pints of blood. One doctor visit per day except for intensive care or consultation.	Limited to 3 routine Doctor's visits per month. Cost and limitations as outlined in Title XVIII.	Not provided	2 visits per week in SNF. Transportation cost of physician not covered.

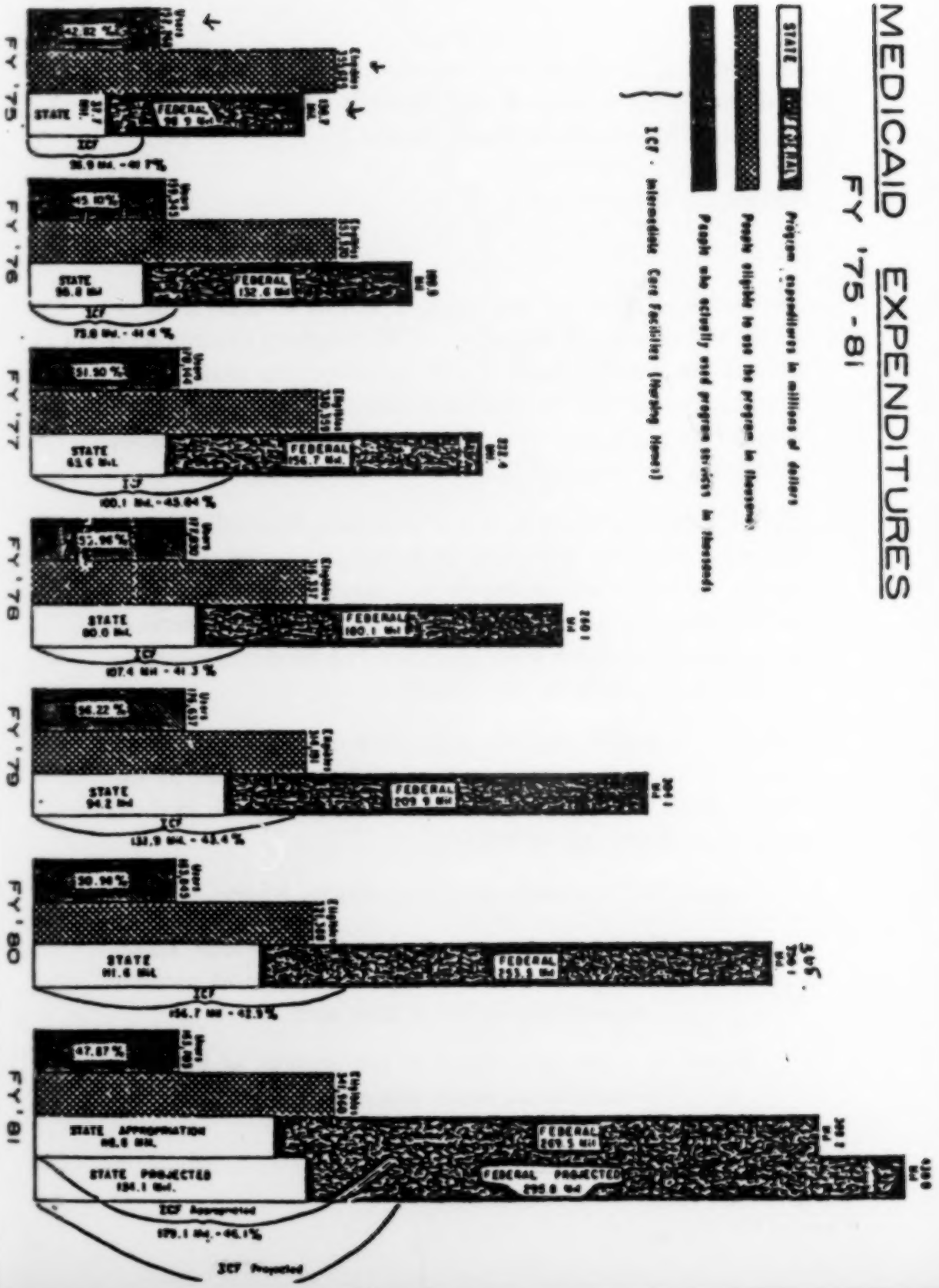
Hawaii	Hospital admissions are authorized for following number of days: Medical and surgical—8 days. Confinement and delivery—4 days. T. & A.—2 days. Psychiatric—10 days. Prior authorization is required for any non-emergency admission such as for elective surgery; approval for extension is required for additional days.	Prior authorization required	Prior authorization required	For patients in skilled nursing facilities limited to 2 visits per month except during acute episodes when additional visits are authorized.
Idaho	Limited to 40 days per admission. Length of stay subject to professional review for appropriateness and necessity, but will not exceed forty days per admission.	Prior authorization is required before payment.	Prior authorization is required before payment.	Physician services related to abortion or abortion related services will not be provided unless the abortion or abortion related services are recommended by 2 consulting physicians who state that it is necessary to save the life of the mother, 2 consulting physicians' recommendations that the mother will suffer severe and long lasting physical health damage if the fetus is carried to term; that in the case of rape or incest, the incident is reported promptly to a law enforcement agency or public health agency and the pregnancy is a result of rape or incest as determined by the court.
Illinois	Psychiatric services limited to an initial period of 10 days and a possible 10 day extension with prior approval. There is a maximum of 45 inpatient days per year.	No limitations	No limitations	No limitations.
Indiana	No limitations	No limitations	No limitations	No limitations.
Iowa	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Virginia	14 days per admission	No limitations	No limitations	Cosmetic surgical procedures are not covered unless performed for physiological reasons. Routine physicals and immunizations are not covered except that well-child examinations in a private physician's office are covered for foster children. Prior authorization is required for refraction and eyeglasses. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health to the mother if the fetus were carried to term. Substantial endangerment of health includes endangerment of the life of the mother.
Washington	Admission and length of stay determined by PSRO.	Prior approval of admission	No limitations	1 visit per month in office, home, skilled nursing facility, and intermediate care facility. 2 per month in extended care facility. 1 per day in hospital, additional calls must be justified.
West Virginia	60 days per Fiscal Year	Prior approval of admission	Prior approval required	No limitations.
Wisconsin	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.	Prior authorization required	Prior authorization required	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.
Wyoming	14 days per spell of illness	No limitations	No limitations	Physical examinations limited to 1 yearly after 3rd year of life; nursing home visits limited to 1 routine visit per month.

DEFENDANTS' EXHIBIT

D- 2



DEFENDANTS' EXHIBIT D-4

February 12, 1981

Mr. Ben C. Crim, Assistant Commissioner
Medicaid Administration & Coordination
Tennessee Department of Public Health
283 Plus Park Boulevard
Nashville, Tennessee 37217

Dear Ben:

Attached are Tables 1, 2 and 3 which provide an analysis of inpatient utilization and the impact of the proposed limitation on users of inpatient services. For purposes of this analysis, the utilization of services by Medicare Medicaid patients has been included since any utilization of services by these people will not be affected bya proposed limitation on patient days.

Table 4 is an analysis of the impact on patient days utilization of the proposed 14 day limitation on the total Medicaid user community. Tables 5 and 6 are the patient days analysis for minority and handicapped patient days users. The utilization of services by recipients who have both Medicare and Medicaid coverage has not been included in these tables.

Tables 7, 8 and 9 were used to determine the number of Medicare Medicaid users. I have also enclosed copies of the reports which provided the source of the information in these tables. The reports are as follows:

Report A: Medically and Categorically Needy

Report B: Medically and Categorically Needy Usage Analysis for *Acute* Care Medicaid patients only by number of days used

Report C: The total pages of the analysis of inpatient utilization which includes psychiatric services but excluded crossovers.

Report A, which is the beginning point of this analysis, balances to MARS report HMGR543 for inpatient category of service.

Sincerely,

William B. Shaw
Program Director

WBS/js

enclosures

DEFENDANTS' EXHIBIT D-4(a)

Table 1

INPATIENT USAGE ANALYSIS
ALL USERS FY 79/80

No. Days Utilized	Medicaid Med. Needy	Medicaid Categ. Needy	Total	Cumul. Users Affected	% Users Served
0	100	23	123	-	-
1	3672	637	4309	-	-
2	8108	881	8989	-	-
3	6321	775	7096	-	-
4	4212	516	4728	-	-
5	3276	496	3772	-	-
6	2731	407	3138	-	-
7	2239	352	2591	-	-
8	1731	304	2035	-	-
9	1323	290	1613	-	-
10	1181	243	1424	-	-
11	975	200	1175	-	-
12	839	180	1019	-	-
13	780	145	925	-	-
14	696	158	854	7279	92.56
15	565	120	685	6594	93.27
16	568	119	687	5907	93.97
17	482	123	605	5302	94.59
18	433	101	534	4768	95.14
19	389	106	495	4273	95.64
20	3320	953	4273	-	-
	43941	7129	51070		
Medicare	-	-	47051		
Medicaid					
Grand Total Users			98121		

(% Users Served = Total Users - Cumul. Users Affected / Total Users

DEFENDANTS' EXHIBIT D-4(b)

Table 2

INPATIENT USAGE ANALYSIS
MINORITY FY 79/80

No. Days Utilized	Minority Users Black	Other	Total Minor. Users	% Minor. Users Served	Cumul. Users Affected
0 - 13	17611	494	18105	-	-
14	262	17	279	93.25	2248
15	193	16	209	93.88	2039
16	214	20	234	94.58	1805
17	175	17	192	95.10	1613
18	146	15	161	95.64	1452
19	139	11	150	96.09	1302
20	1186	116	1302	-	-
	19926	706	20632		
Medicare/Medicaid	11302	1419	12721		
Grand Total			33353		

$$\% \text{ Minority Users Served} = \frac{\text{Grand Total - Cumul. Users Affected}}{\text{Grand Total}}$$

DEFENDANTS' EXHIBIT D-4(c)

Table 3

INPATIENT USAGE ANALYSIS
HANDICAP FY 79/80

No. Days Utilized	Handicapped Users Disabled	Blind	Total Handicapped Users	% Handicapped Served	Cumul. Users Affected
0 - 13	11511	253	11764	-	-
14	458	13	471	84.40	4617
15	385	8	393	85.73	4224
16	382	7	389	87.04	3835
17	349	5	354	88.24	3481
18	320	8	328	89.35	3153
19	304	5	309	90.39	2844
20	2804	40	2844	-	-
	16513	339	16852		
Medicare/ Medicaid	12169	588	12757		
Grand Total Handicapped Served	28682	927	29609	-	

$$\% \text{ Handicapped Served} = \frac{\text{Total Handicapped Users - Cumul. Users Affected}}{\text{Total Handicapped Users}}$$

DEFENDANTS' EXHIBIT D-4(d)

Table 4

PATIENT DAYS IMPACT ANALYSIS
ALL USERS FY 79/80

No. Days Utilized	Total Patient Days	Users Affected	Patient Days Cutback (14 Day Limit)
0	-	-	-
1	4,309	-	-
2	17,978	-	-
3	21,288	-	-
4	18,912	-	-
5	18,860	-	-
6	18,828	-	-
7	18,137	-	-
8	16,280	-	-
9	14,517	-	-
10	14,240	-	-
11	12,925	-	-
12	12,228	-	-
13	12,025	-	-
14	11,956	-	-
15	10,275	685	685
16	10,992	687	1,374
17	10,285	605	1,815
18	9,612	534	2,136
19	9,405	495	2,475
20	85,460	4,273	25,638
Total Days:	348,512	Cutback Days:	34,123

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{34,123}{348,512} = 9.79\%$$

DEFENDANTS' EXHIBIT D-4(e)

Table 5

PATIENT DAYS IMPACT ANALYSIS
MINORITY USERS FY 79/80

No. Days Utilized	Total Patient Days	Users Affected	Patient Days Cutback (14 Day Limitation)
1 - 13	80,437	-	-
14	3,906	-	-
15	3,135	209	209
16	3,744	234	468
17	3,264	192	576
18	2,898	161	644
19	2,850	150	750
20	26,040	1,302	7,812
Total Days:	126,274	Cutback Days:	10,457

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{10,457}{126,274} = 8.28\%$$

DEFENDANTS' EXHIBIT D-4(f)

Table 6

PATIENT DAYS IMPACT ANALYSIS
HANDICAP USERS FY 79/80

No. Days Utilized	Patient Days	Users Affected	Patient Days Cutback (14 Day Limit)
0 - 13	70,254	-	-
14	6,594	-	-
15	5,895	393	393
16	6,224	389	778
17	6,018	354	1,062
18	5,904	328	1,312
19	5,814	309	1,545
20	56,800	2,844	17,064
Total Days:	162,703		22,154

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{22,154}{162,703} = 13.61\%$$

DEFENDANTS' EXHIBIT D-4(g)

Table 7

TOTAL USERS SERVED UNDER THE MEDICAID PROGRAM VIA MEDICARE (FY 79/80)

	Unduplicated Total	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Medically Needy	10342	1202	9136	4	3	1596
Categorically Needy	36709	10100	25194	1414	585	10573
Grand Total	47051	11302	34330	1419	588	12169

Note:

1. The grand total of unduplicated users shown above (47051) is comparable to the count of 42748 shown in Section J of the HCFA 2082. Since the HCFA 2082 is prepared immediately after the close of the Federal Fiscal Year (September 30), it represents approximately 11 months services rather than the full twelve months services used to develop the chart above.

DEFENDANTS' EXHIBIT D-4(h)

Table 8

INPATIENT SERVICES ANALYSIS
MEDICALLY NEEDY FY 79/80

	Unduplicated Total Users	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Total Inpatient Category of Service	17950 (1.)	2711	15207	32	10	5248
(minus) Medicaid Acute Care and Psychiatric	7608 (2.)	1509	6071	28	7	3652
(net) Recipients Served by Medicare/Medicaid jointly	10342 (3.)	1202	9136	4	3	1596

Notes:

1. Report of all paid claims for services rendered during FY 79/80 for inpatient services provided in acute care facilities for Medicaid recipients.
2. Report of Medicaid recipients receiving services in acute care facilities and reimbursed by the Medicaid Program. Includes the inpatient psychiatric program.
3. Those individuals receiving service under the Medicaid Program via reimbursement for the Medicare deductible.

DEFENDANTS' EXHIBIT D-4(i)

Table 9

INPATIENT SERVICES ANALYSIS
CATEGROICALLY NEEDY FY 79/80

	Unduplicated Total Users	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Total Inpatient Category of Service (minus) Medicaid Acute Care & Psychiatric	81720 (1.)	29048	50555	2117	922	23816
	45011 (2.)	18948	25361	702	337	13243
(net) Recipients served by Medicare/Medicaid jointly	36709 (3.)	10100	25194	1415	585	10573

Note: The notes for the previous page on the medically needy are applicable to the data on this page. (1., 2., 3.)

DEFENDANTS' EXHIBIT D-6

ANALYSIS OF IN-PATIENT UTILIZATION FOR HANDICAPPED AND NON-HANDICAPPED MEDICAID RECIPIENTS

The colums of Table 1 labeled "Number of Recipients Receiving Service" are taken from claims data provided by EDS. The impact on the handicapped of the implementation of cost containment methods which will limit the number of in-patient hospitalization days which are reimbursible to 14 cannot be accurately assessed by comparing the number of recipients served between the handicapped and the non-handicapped categories. Some allowance must be made for the fact that the number of eligible Medicaid recipients differ between the handicapped and the non-handicapped group. To clarify this, suppose there were 100 Medicaid recipients in the non-handicapped group and 100 Medicaid recipients in the handicapped group. Further, suppose that in the handicapped group the 100 recipients were eligible during the entire 12 month period, but in the non-handicapped group, the 100 recipients were eligible only during the month of January. Thus, the 100 handicapped Medicaid recipients would have access to medical service during the entire 12 month period. On the other hand, the non-handicapped Medicaid recipients would have access to in-patient medical services only one month out of the entire year. Also, assume that the handicapped and the non-handicapped utilize in-patient medical services at the same rate, and assume both the handicapped and the non-handicapped utilization rate is 1% of the population per month. Therefore, in the handicapped group you would expect 12 recipients to be hospitalized throughout the 12 months. However, in the non-handicapped group since the 100 Medicaid recipients were eligible for only one month, you would expect only one in-patient hospitalization for the non-handicapped group. Thus, if you utilized the total number of hospitalizations [DEFENDANTS' EXHIBIT

D-6(a)] to comparehandicapped and non-handicapped it would appear that the handicapped utilize at 12 times the rate as the non-handicapped. In addition, even if you normalized the number of hospitalizations by dividing by the total number of eligible recipients during the year, the handicapped would still appear to have a utilization rate that was 12 times the non-handicapped rate. Therefore, the appropriate denominator for computing in-patient utilization rates would be the number of person-years of eligibility in the non-handicapped and the handicapped categories. The number of person-years is calculated by determining the number of eligibles on a monthly basis, summing the number of eligibles in each month over 12 months and dividing by 12 to get an estimate of person-years of eligibility. In this simplified example, the number of person-years of eligibility for the non-handicapped group would be 100 x 1 ÷ 12 = 8 1/3. For the handicapped group, the number of person-years of eligibility would be 100 x 12 ÷ 12 = 100. If the number of hospitalizations in the handicapped and the non-handicapped group are compared using the person-years of eligibility as a denominator, the two rates will be identical.

The utilization rates given in Table 1 were computed by dividing the number of recipients receiving service by the number of person-years of eligibility. For example, there 3467 non-handicapped Medicaid recipients who received in-patient services of 1 day hospitalization. There were 258,656.9 person-years of eligibility for the non-handicapped group. Thus, the utilization rate for 1 day of in-patient service for the non-handicapped group is 3467 ÷ 258,656.9 x 1000 which gives a utilization rate of 13.4 persons hospitalized per 1000 person-years of eligibility. Except for 0, 1, 2 and 3 days of in-patient service, the handicapped group utilizes in-patient hospitalization services at a much higher level than the non-handicapped Medicaid recipients.

[DEFENDANTS' EXHIBIT D-6(b)] The column headed "% of Total Utilization" is computed by dividing the utilization

rates in the preceding column and by the total utilization rate for the entire category of recipients receiving service. For example, in the non-handicapped group who received 1 day of in-patient service who had a utilization rate of 13.4 persons hospitalized per 1000 person-years of eligibility accounted for 10.1% of the total of the 132.6 persons hospitalized per 1000 person-years of eligibility. When comparing the non-handicapped and the handicapped categories, Table I shows that handicapped recipients utilize in-patient services at a higher rate than non-handicapped recipients.

DEFENDANTS' EXHIBIT D-6(c)

Table 1 COMPARISONS OF MEDICAID IN-PATIENT HOSPITAL UTILIZATION RATES FOR HANDICAPPED AND NON-HANDICAPPED PERSONS DATES OF SERVICE: 7/1/79 to 6/30/80

	NONHANDICAPPED			HANDICAPPED		
Number of Days of Inpatient Service	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization
0	110	.4	.3	13	.2	.1
1	3467	13.4	10.1	932	12.1	5.5
2	7614	29.4	22.2	1355	17.6	8.0
3	5787	22.4	16.9	1309	17.0	7.8
4	3472	13.4	10.1	1256	16.3	7.3
5	2643	10.2	7.7	1129	14.6	6.7
6	2100	8.1	6.1	1038	13.5	6.2
7	1598	6.2	4.7	993	12.9	5.9
8	1182	4.6	3.5	853	11.1	5.1
9	940	3.6	2.7	673	8.7	4.0
10	752	2.9	2.2	672	8.7	4.0

Number of Days of Inpatient Service	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization
11	623	2.4	1.8	552	7.2	3.3
12	526	2.0	1.5	493	6.4	2.9
13	429	1.7	1.3	496	6.4	2.9
14	383	1.3	1.1	471	6.1	2.8
15	292	1.1	.8	393	5.1	2.3
16	298	1.2	.9	389	5.1	2.3
17	251	1.0	.8	354	4.6	2.1
18	206	1.8	1.4	328	4.3	2.0
19	186	.7	.5	309	4.0	1.8
20	1429	5.5	4.1	2844	37.0	16.9
TOTAL	34288	132.6		16852	219.1	

DEFENDANTS' EXHIBIT D-7

STATISTICAL OVERVIEW - TENNESSEE MEDICAID PROGRAM SERVICES
FISCAL YEAR - 1979-80

I. PROGRAM EXPENDITURES:

TOTAL -	$ 365,120,000
FEDERAL -	253,515,000
STATE -	111,605,000

II. SUMMARY OF PROGRAM ELIGIBLES[1] AND EXPENDITURES[2]:

	TOTAL -	341,960	$ 365,120,000
CATEGORICALLY	NEEDY -	307,350	$ 233,000,000
MEDICALLY	NEEDY -	34,610	$ 132,120,000

III. TOTAL NUMBER HANDICAPPED ELIGIBLES: 90,668
TOTAL HANDICAPPED EXPENDITURES: $ 136,291,504

IV. TOTAL NUMBER MEDICARE BUY-IN RECIPIENTS: 90,978
TOTAL BUY-IN EXPENDITURES[3]: $ 24,515,718

V. SUMMARY OF PROGRAM EXPENDITURES BY MAJOR COST CATEGORIES:

		EXPENDITURES
A.	INPATIENT HOSPITAL	$ 84,604,137
B.	SKILLED NURSING HOME	7,446,602
C.	INTERMEDIATE CARE	156,767,654
D.	PHARMACY	39,622,536
E.	PHYSICIAN, DENTIST, LAB, X-RAY	33,526,462
F.	OUTPATIENT	14,122,087
G.	OTHER (Home Health; EPSDT; Community Health Clinics; Family Planning)	4,979,429

1. All figures on eligibles and recipients are based on data for the month of June, 1980.
2. All figures on expenditures include both state and federal funds combined.
3. Co-insurance, deductions and premiums for medicare.